Health Matrix: The Journal of Law-Medicine

Volume 3 | Issue 1

1993

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PROMOTING BETTER HEALTH CARE: POLICY ARGUMENTS FOR CONCURRENT QUALITY ASSURANCE AND ATTORNEY-CLIENT HOSPITAL INCIDENT REPORT PRIVILEGES

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I. INTRODUCTION: THE QUALITY-CONFIDENTIALITY CONNECTION

HOSPITAL INCIDENT reports are dual purpose documents, used both by the hospital attorney to prepare for potential litigation and by hospital quality managers to identify and correct problems so that the quality of health care is improved.[1] To promote full disclosure of truthful information in medical malpractice law suits, some courts have begun to compel discovery of hospital incident reports requested by plaintiffs' attorneys and to admit them into evidence at trial, declaring that such reports are neither protected by attorney work product immunity[2] nor inadmissible as hearsay.[3] The attorney-client privilege[4] does not consistently protect incident reports because they are prepared for other persons, such as liability insurers and hospital risk managers and quality committees, as well as for the attorney.[5] Because health care prov-

† This paper was written under the supervision of Professor Maxwell J. Mehlman.

1. *See infra* § II for further discussion of the nature and purposes of hospital incident reports.

2. *See, e.g.*, cases arguing for work product immunity: Sims v. Knollwood, 511 So. 2d 154 (Ala. 1987); State ex rel. Faith Hosp. v. Enright, 706 S.W.2d 852 (Mo. 1986); Kay Laboratories v. Dist. Court of Colo., 653 P.2d 721 (Colo. 1982); Payne v. Howard, 75 F.R.D. 465 (D.D.C. 1977); Hospital Corp. of America v. Dixon, 330 So. 2d 737 (Fla. 1976). *See infra* note 48 for a full discussion of work product arguments for hospital incident reports.

3. *See infra* note 47 for a discussion of the inapplicability of the hearsay exception and treatment of hospital incident reports as admissions by defendant hospitals.

4. *See infra* § III for full discussion of the attorney-client privilege.

5. *See, e.g.*, cases holding that attorney-client confidentiality is lost when the informa-

iders' conduct is influenced by potential legal consequences, this trend by the courts to compel discovery of hospital incident reports will discourage health care providers from making immediate, full disclosure; rather, health care providers will likely report only minimal factual descriptions of accidents already contained in the patient's chart.[6] Incident reports will no longer indicate witnesses' mental impressions (opinions) regarding causation, potential liability, and suggestions for correcting the causes of incidents. They will simply notify hospital attorneys of the facts of an incident which might lead to a lawsuit against the hospital. The second useful purpose of incident reports—improving the quality of health care—will be thwarted because of the health care worker's fear that the information contained in the reports will be used to demonstrate his or her negligence in court.[7]

This Note addresses the two different, but equally important, justifications for hospital incident report privilege: to encourage full disclosure of information to hospital attorneys for liability loss prevention by recognizing the attorney-client privilege, and to promote full disclosure of the information to hospital personnel who are responsible for reducing internal risk and improving the quality of care by adopting a new concurrent privilege, a quality assurance privilege. The Note examines how courts and state statutes have previously dealt with the issue of privilege: through the attorney-client privilege,[8] through the medical peer review committee privi-

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tion has been shared with other parties: State ex rel. Children's Medical Ctr. v. Brown, 59 Ohio St. 3d 194 (1991); Dunkin v. Silver Cross Hosp., 573 N.E. 2d 848 (Ill. App. 1991); White v. New York City Health & Hospitals Corp., No. 88 Civ. 7536, 1990 U.S. Dist. LEXIS 3008 (S.D. N.Y. 1990); Hospital Corp. of America v. Dixon, 330 So. 2d 737 (Fla. 1976); Bernardi v. Community Hosp. Ass'n, 443 P.2d 708 (Colo. 1968).

6. *See* White v. New York City Health & Hosp. Corp., No. 88 Civ. 7536, 1990 U.S. Dist. Lexis 3008, at 16-22 (quoting Wayne M. Austin, DOH Director of Bureau of Hospital Services) (although this court denied the incident report privilege, it validated the confidentiality rationales offered by a Department of Health official). The court stated

> [u]nless incident reports [are] protected from disclosure hospitals might be reluctant to adhere to the reporting requirements or their reports might not be complete or forthright. [citations omitted]. Hospitals could be exposed to liability as a result of the events required to be reported and therefore a reluctance to file reports could be anticipated . . . [P]rompt identification of hospital deficiencies can prevent the recurrence of problems. The State therefore has a strong governmental interest in ensuring the confidentiality of hospital incident reports.

Id. (quoting Wayne M. Osten, DOH Director of Bureau of Hospital Services, para. 9).

7. *See Id.*

8. *See, e.g.*, cases arguing for attorney-client privilege: Sierra Vista v. Shaffer, 56 Cal. Rptr. 387 (1967); Bernardi v. Community Hosp. Ass'n, 443 P.2d 708, 715-16 (Colo. 1968); St. Louis Little Rock Hosp., Inc. v. Gaertner, 682 S.W.2d 146 (Mo. 1984); Hawkins v. Dist. Court, 638 P.2d 1372 (Colo. 1982); Clark v. Norris, 734 P.2d. 182 (Mont. 1986); *In re* Fran-

lege,[9] and by considering the policy underlying the subsequent remedial measures rule of evidence.[10]

This Note proposes a model rule establishing concurrent hospital incident report privileges, attorney-client privileges and quality assurance privileges, and defends the rule[11] based on the policy underlying the peer review privilege and the subsequent remedial measures rule.[12] If the plaintiffs' attorneys use hospital incident reports to prove negligence, health care workers will not freely critique their fellow workers' actions. Quality improvement personnel will not have the confidential information as needed for taking corrective action unless there are two privileges at work, the same communication must be privileged in the hands of both the attorney and the quality assurance personnel.

II. BACKGROUND: HOSPITAL DOCUMENTATION: HOW HOSPITAL INCIDENT REPORTS ARE DIFFERENT FROM THE MEDICAL RECORD.

The proliferation of medical malpractice suits, which began in the 1980s,[13] has caused physicians, nurses, and other hospital per-

cis v. St. Thomas Hosp. No. C.A. 8556 (C.A. Ohio Dec. 7, 1977). *See infra* § III(A) and accompanying text for the development of the attorney-client privilege.

9. *See, e.g.*, cases arguing for analogy to peer review privilege: Gallagher v. Detroit-Macomb Hosp. Ass'n, 431 N.W.2d (Mich. 1990); Beth Israel Hosp. Ass'n v. Board of Registration in Medicine, 515 N.E.2d 574 (Mass. 1987); Willing v. St. Joseph Hosp., 531 N.E.2d 824 (Ill. App. Ct. 1988); Bredice v. Doctors Hosp., 51 F.R.D. 187 (D.D.C. 1970); Laws v. Georgetown Univ. Hosp., 656 F. Supp. 824 (D.D.C. 1987); Santa Rosa Memorial Hosp. v. Superior Court of Sonoma County, 220 Cal. Rptr. 226 (1985); Marsh v. Lake Forest Hosp., 519 N.E.2d 504 (Ill. App. Ct. 1988); Flannery v. Lin, 531 N.E.2d 403 (Ill. App. Ct. 1988). *See infra* § III.B.1, for an explanation of peer review privilege and why its policies are a powerful defense of hospital incident report privilege.

10. The subsequent remedial measures argument is offered through an analysis of the role of incident reports in improving the quality of health care. *See* text *infra* § III(B)(3) for a discussion of the subsequent remedial measures rule and policy.

11. *See infra* § IV(A)(1) and accompanying text. Some of the objections are that incident reports do not meet the standards for attorney-client privilege, and plaintiffs need for access to timely information about hospital accidents which would not otherwise be available to them through the medical record.

12. *See, e.g.*, Bredice v. Doctor's Hosp. Inc., 51 F.R.D. 187 (D.D.C. 1970); Shelton v. Morehead Memorial Hosp., 347 S.E.2d 824, 828 (N.C. 1986) (granting hospital incident report privilege because the societal interest in improving health care will be promoted by open, confidential communication among health care providers).

13. *See generally* David J. Nye, et al. *The Causes of the Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances*, 76 GEO. L.J. 1495 (1988). Some alarming statistics evidence the crisis: although the overall frequency of claims (number of claims filed) has not increased significantly, the severity of claims (amount of damages awarded per claim) has increased dramatically especially in such areas as pediatrics, from approximately

sonnel to practice defensive medicine.[14] To ward off potential liability, not only are hospital personnel ordering more tests and procedures, but also a greater percentage of health care workers' time is consumed with documentation, the preparation of the medical record, and completion of a variety of other paperwork required by insurers, attorneys, accreditation agencies, and review boards.[15]

The medical record, commonly referred to as the patient's "chart", is intended to be an objective factual recounting of health care workers' observations and diagnostic reports of a patient.[16] Several federal and state governmental agencies and the Joint Commission on the Accreditation of Health Care Organizations (hereinafter "JCAHCO") require medical records for licensure, reimbursement, and accreditation purposes.[17] The chart includes, but is not limited to, laboratory results, descriptions of procedures performed upon the patient, medications given and the response to them, supplies used in the patient's care, dialogue with the patient, and any consent forms the patient may have signed authorizing treatment.[18]

Most states have statutory penalties for inaccurate, incomplete, or falsified hospital records,[19] which help to insure that the chart is

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$56,000 in 1975 to $304,000 in 1986; neurosurgery, from about $34,000 in 1975 to $194,000 in 1986; and obstetrics and gynecology, from $14,000 in 1975 to $161,000 in 1986. Insurance costs for all physicians and hospitals increased from $2.5 billion in 1983 to $4.7 billion in 1985. Ninety-four percent of Florida obstetricians and gynecologists (a state and specialty with some of the highest increases in malpractice premiums) increased their fees in response to the increased premiums, but relative incomes still declined.

14. Defensive medicine may mean ordering more tests and utilizing more conservative therapies or more drastic measures, such as refusing to treat patients for fear of liability. *See* Jon Nordheimer, *Doctors Withhold Services in Protest on Insurance*, N.Y. TIMES, Dec. 10, 1986 at A25.

15. *See* JANINE FIESTA, THE LAW AND LIABILITY: A GUIDE FOR NURSES 173-175 (2nd ed. 1988) (noting the relationship between malpractice litigation and the necessity for increased documentation because omissions in documentation could be used to establish negligence — if something is not documented, plaintiff's attorneys allege it was not done for the patient). *Cf.*, Julie Rovner, *Congress Feels the Pressure of Health-Care Squeeze*, 49 CONG. Q., 414, 414 (1991). "[H]ealth care providers . . . are drowning in . . . 'paper snow.'" *Id.*

16. *See, e.g.*, GINNY W. GUIDO, LEGAL ISSUES IN NURSING: A SOURCE BOOK FOR PRACTICE (1988); WILLIAM H. ROACH, JR. ET AL., MEDICAL RECORDS AND THE LAW 126 (1985) (describing the legal requirements for the contents of the medical record).

17. *See* CARMELLE P. COURNOYER, THE NURSE MANAGER AND THE LAW 219-220 (1989); FIESTA, *supra* note 15, at 174-175; GUIDO, *supra* note 16, at 97-98.

18. *See* GUIDO, *supra* note 16, at 98 ("Basic information that should be recorded for any patient includes (1) personal data as name, date of birth, sex, marital status, occupation, and person(s) to be contacted for emergencies, (2) financial data as to one's health insurance carrier with assignment of rights, patient employer, and person responsible for payment of the final bill, and (3) medical data").

19. *See* ROACH, *supra* note 16, at 15 and Appendix B. *See, e.g.*, ARIZ. REV. STAT.

a thorough factual representation of the patient's hospitalization both for internal and external use.[20] Although health care providers may complain about the volume of documentation they are required to complete, most of the documentation serves useful purposes, benefits the providers themselves, and ultimately benefits their patients.[21]

The hospital incident report is one controversial form of documentation with great potential benefits for both providers and patients.[22] A hospital incident is "any event or circumstance not consistent with the normal routine operations of the hospital and its staff or the routine care of a patient. It may be an error, an accident, or a situation which could have, or has, resulted in injury to a person or damage to hospital equipment or property."[23] Incidents include events such as losing a patient's belongings,[24] a minor medication error which results in no injury to the patient, a nurse accidentally sticking himself or herself with a dirty needle, a visitor falling on a freshly mopped floor, or a bathtub drowning of an unattended patient. Incident reports can provide an invaluable addition to the simple factual description recited in the medical record provided they detail mental impressions and other subjective information.[25] Currently, however, health care workers are inhibited about including this subjective information for fear that it will be disclosed to persons outside the hospital who could use it to incriminate them in some way, such as opposing counsel in a lawsuit.[26]

Prepared subsequent to an accident or otherwise non-routine oc-

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ANN. § 36-125.05 (1992); GA. CODE ANN. §§ 24-7-8, 31-8-34 (1991); MISS. CODE ANN. § 41-9-63 (1972); NEB. REV. STAT. § 71-2024 (1990).

20. *See* FIESTA, *supra* note 15, at 173-193 (internal reports are for use in problem-solving within the institution; external documentation is mandated by insurers, government agencies and accreditors).

21. For example, careful documentation on insurance forms and quality assurance reports may result in insurance company reimbursement to the hospital and physician for a patient who would not ordinarily meet the criteria for payment. The patient benefits, from a purely financial standpoint, by not being personally responsible for the bill. The hospital benefits by receiving payment expeditiously or receiving payment it might not have received at all.

22. *See* Gladys Duran, *Positive Use of Incident Reports*, 53 HOSPS. 60, 60 (1979); JOHN F. MONAGLE, RISK MANAGEMENT: A GUIDE FOR HEALTH CARE PROFESSIONALS 29 (1985).

23. MONAGLE *supra* note 22, at 29.

24. *See, e.g.*, John C. Lincoln Hosp. & Health Ctr. v. Superior Court of Arizona, 768 P.2d 188, 191 (Ariz. Ct. App. 1989).

25. *See* Appendix A for a sample hospital incident report.

26. *See* GUIDO, *supra* note 16, at 108 ("Do not infer assumptions . . . [a]bove all, never imply liability").

currence in the hospital, incident reports serve two basic purposes. First, incident reports furnish the hospital's attorney with an account of the events and circumstances which might lead to a legal claim against the hospital.[27] Second, they pinpoint both procedures and practices which need to be changed and employees who may need further education or discipline.[28] This improves the quality of care[29] provided to patients and makes a safer environment for employees and visitors to the hospital.[30] Alerting hospital attorneys to potential litigation is commonly referred to as the risk management (hereinafter "RM") function of incident reports, and, arguably, the RM use of incident reports is protected by the attorney-client privilege.[31] Identifying problem procedures and employees needing remedial attention is known as the quality assurance (hereinafter "QA") function.[32] Although improving the quality of care is probably a more compelling reason than protecting the hospital from a lawsuit for granting privilege to hospital incident reports, at present courts are split on whether reports sent to persons other than the attorney are entitled to privilege.[33]

The quality assurance movement in hospital care dates from the

27. *See generally* Elizabeth L. Allan & Kenneth N. Baker, *Fundamentals of Medication Error Research*, 47 AM. J. HOSP. PHARM. 555, 561 (1990); Karen Puetz, *QA Communique: Development of an Incident Reporting System*, QRB Aug. 1988, 245; SHIZUKO Y. FAGERHAUGH, ET AL., HAZARDS IN HOSPITAL CARE: ENSURING PATIENT SAFETY (1987). Each discusses the role of incident reports in alerting the hospital attorneys to potential claims.

28. *See* MONAGLE, *supra* note 22, at 29-30. Some authors suggest positive reinforcement techniques to encourage incident reporting in spite of the potential for discipline, focusing on education rather than punishment. *See, e.g.*, Duran, *supra* note 22, at 60.

29. Although quality is a value judgment, this note adopts Thompson's definition of quality: "the optimal achievable result for each patient, the avoidance of [health care worker]-induced (iatrogenic) complications, and the attention to patient and family needs in a manner that is both cost-effective and reasonably documented." NANCY O. GRAHAM, QUALITY ASSURANCE IN HOSPITALS" STRATEGIES FOR ASSESSMENT AND IMPLEMENTATION 9 (2d ed. 1990), quoting Richard Thompson, personal communication, May 1980.

30. *See*, JEAN G. CARROLL, RESTRUCTURING HOSPITAL QUALITY ASSURANCE 79 (1984).

31. *See infra* § III for a further discussion of this privilege.

32. PUETZ, *supra* note 27, at 245 ("The incident report serves at least two purposes. As a basis for QA activities, it can identify deficits in hospital systems or in employees' behavior or knowledge. For RM, it serves as evidence for defense of an actual or potential lawsuit.").

33. *See, e.g.*, cases granting privilege to incident reports: Bredice v. Doctor's Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970); Sierra Vista Hosp. v. Superior Court, 56 Cal. Rptr. 387 (1967); Enke v. Anderson, 733 S.W.2d 462 (Mo. Ct. App. 1987); and cases denying privilege to incident reports: Clark v. Norris, 734 P.2d 182 (Mont. 1987); State ex rel Children's Medical Ctr. v. Brown, 571 N.E.2d 724 (Ohio 1991); Bernardi v. Community Hosp. Assn., 443 P.2d 708 (Colo. 1968).

efforts of Florence Nightingale in the 1860s.[34] The Joint Commission on the Accreditation of Health Care Organizations (JCAHCO), established in 1952 as the Joint Commission on the Accreditation of Hospitals, (hereinafter "JCAH"), began to promote "medical audits" in 1955.[35] In 1981 JCAHCO executed its Quality Assessment Standard which compelled hospitals desirous of accreditation to develop a single medical audit system that integrated incident reports; mortality, tissue, transfusion, and antibiotic monitoring studies; and medical records and privileging standards.[36] In 1986 JCAH changed its name to JCAHCO and implemented it Agenda for Change, a program aimed at improving the quality of health care by monitoring health care facilities' outcomes.[37] The law which created Health Maintenance Organizations (hereinafter "HMOs") in 1973 required federally subsidized HMOs to develop quality assessment programs.[38] Since their implementation, both Medicare and Medicaid programs require hospitals to perform "utilization review" to assess the quality of care provided.[39] Professional Standards Review Organizations (hereinafter "PSROs") were created by the 1972 Social Security Act Amendments to provide external quality review for hospitals receiving Medicare and Medicaid reimbursement.[40] Because of the external pressures from these various licensure, accreditation, and reimbursement programs, hospitals have developed internal quality assurance and risk management programs to ensure that the hospitals are in compliance with the external quality standards, to improve the hospitals' outcomes where possible, and to generate the reports required by the external agencies.

Although the two uses of hospital incident reports—liability defense and quality improvement—are different, the distinction between quality assurance and risk management is blurred when the attorney advises the hospital to implement corrective action (subsequent remedial measures) based on information contained in the incident reports. The attorney's area of expertise is the application of the law to a particular hospital situation. The medical, nursing,

34. *See* GRAHAM, *supra* note 29, at 6-7. Nightingale developed a statistical system for comparing mortality rates among hospitals.

35. *Id.* at 7-8.

36. *Id.* at 8.

37. *Id.*

38. *Id.*

39. *See* RICHARD H. EGDAHL & PAUL M. GERTMAN, QUALITY ASSURANCE IN HEALTH CARE 76-81 (1976).

40. *Id.* at 80.

pharmacy, and engineering personnel use their expertise to translate the lawyer's advice into improving hospital practice. Hospital actions triggered by incident reports that improve the quality of care for patients also reduce the hospital's exposure to litigation, which could lower the cost of health care to consumers.[41] If a hospital were to implement safer procedures based on data gathered from incident reports, both patients and health care workers would benefit. Positive results would include fewer accidents and shorter stays in the hospital.[42] For these reasons, full and confidential disclosure of information surrounding the "incident" to *both* attorneys and quality assurance advisors is crucial to improving the quality of health care and to the efficient functioning of hospitals. If the dual purpose incident report remains confidential by disallowing discovery by a plaintiff, it may contain a useful, evaluative "self-critical analysis";[43] a health care worker, witnesses to the incident, Quality Assurance (hereinafter "QA") committees, and risk managers will feel uninhibited to hypothesize about the potential causation for an accident or injury and to offer potential solutions or remedial measures which may prevent similar problems from occurring in the future.

Medical records tend to have less remedial value than incident reports because they tend to be basic recountings of the facts, without impressions regarding fault or other extenuating circumstances which may have influenced the situation.[44] Because risk managers

41. *See generally*, Eli Ginzberg, *A Hard Look At Cost Containment*, 316 NEW ENG. J. MED. 1151 (1987); *Malpractice Crisis: How Its Hurting Medical Care*, U.S. NEWS & WORLD REP., May 26, 1975, at 26.

42. For example, if it can be shown through incident report data that only the patients in the intensive care unit who were cared for by Nurse X acquired staphylococcus (a bacteria commonly carried on the hands) infections in their surgical wounds, the hospital would be alerted that Nurse X is the infection carrier. Perhaps Nurse X needs more training in aseptic technique, or Nurse X was assigned too many patients so the hospital supervisor should have called in more staff members. If remaining infection-free saves the surgical patient five days in the intensive care unit, the patient and the insurer have been spared the expense. Also the patient has been spared the discomfort of the infection and the cost of the antibiotics to treat it. If Nurse X improves handwashing and wound dressing skills, and the hospital lowers the patient-nurse ratio, fewer patients will die from septic shock or suffer other injuries; therefore, the hospital will have less potential exposure to liability for negligent practices and may cut costs via increased efficiency.

43. *See generally* Note, *The Privilege of Self-Critical Analysis*, 96 HARV. L. REV. 1083 (1983).

44. *See generally*, JEAN G. CARROLL, RESTRUCTURING HOSPITAL QUALITY ASSURANCE 74-79 (1984); and ROBERT D. MILLER, PROBLEMS IN HOSPITAL LAW 287-316 (5th ed. 1986). These books discuss collection and disclosure of patient information through the medical record and incident reports including the importance of confidentiality of patient information from a physician-patient privilege standard.

and attorneys do not review every chart, if no incident report is prepared in addition to the medical record, they may not be made aware of incidents until much later; when the medical record is scrutinized after a lawsuit is brought, memories of the event may be stale and witnesses may no longer be available. This delay and lack of specificity could impair the preparation of an adequate defense by the health care provider's attorneys and increase the likelihood that repeated incidents will occur before the hospital Risk Management (hereinafter "RM"), QA personnel, and attorney become aware of the underlying problem, and take corrective action.[45] Additionally, a pattern of incidents might make it more likely that future mishaps will occur and that the hospital or the physician will be found negligent. The corrective and preventative functions of the incident report would be reduced or eliminated if it is not prepared at all or becomes merely a formalistic repetition of the facts within the chart. Nonetheless, these will be the results if discovery and admissibility of incident reports is compelled[46] as when courts treat the reports as admissions by defendant hospitals[47] or determine that

45. *See* White v. New York City Health & Hospitals Corp., No. 88 Civ. 7536, 1990 U.S. Dist. LEXIS 3008 (S.D.N.Y. Mar. 19, 1990); (hospital not allowed to claim incident report confidentiality privilege in infant kidnapping case); Rees v. Doctor's Hospital, Case No. CA-5226, Slip. Op. (C.A. Ohio Feb. 6, 1980) (hospital denied confidentiality privilege for incident report, court cited need for timely declarations of witnesses). Both cases argue for the need for the timely statements of witnesses.

46. However, the health care provider's primary motivations for any documentation is to provide communication to others so that continuity of patient care is maintained, and as an assessment, planning, research and educational tool, consequently, it is not possible to accurately gauge just how much of a disincentive to full disclosure compelled discovery and admissibility would be. *See* FIESTA, *supra* note 15, at 173; COURNOYER, *supra* note 17, at 219.

47. Admissions are admissible into evidence because of a belief that the party making the statement would not purposely say anything self-incriminating unless it were true.

> (d) Statements which are not hearsay
> A Statement is not hearsay if—
> . . . .
> (2) Admission by party-opponent. The statement is offered against a party and is (A) the party's own statement, in either an individual or a representative capacity or (B) a statement of which the party has manifested an adoption or belief in its truth, or (C) a statement by a person authorized by the party to make a statement concerning the subject, or (D) a statement by the party's agent or servant concerning a matter within the scope of the agency or employment, made during the existence of the relationship, or (E) a statement by a coconspirator of a party during the course and in furtherance of the conspiracy.

FED. R. EVID. 801(d)(2).

Prior to the enactment of the Federal Rules of Evidence in 1975, defendant hospitals' attorneys argued that incident reports were inadmissible hearsay because historically medical records were treated as such. *See, e.g.*, Sligar v. Tucker, 267 So. 2d 54, 55 (Fla. Dist. Ct. App. 1972) (holding that incident reports were routinely prepared and examined by the hos-

pital staff, but declaring that because they were submitted to the liability insurer, they were not a part of the admissible business records; "but even if they were, they would nonetheless retain their privileged status"), *cert. denied*, 271 So. 2d 146 (Fla. 1972). *Cf.* Picker X-ray Corp. v. Frerker, 405 F.2d 916, 922-23 (8th Cir. 1969) (discussing incident reports prepared by hospital staff after a catheter broke off in a patient's artery during a radiologic procedure, the court acknowledged that the incident reports were ordinary business records, but denied admissibility. *See* Roach, Chernoff & Esley, *supra* note 16, at 118 n.4. The Federal Rules of Evidence defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." FED R. EVID. 801(c). Hearsay statements are not admissible into evidence unless the rules provide a specific exception for the statement. FED. R. EVID. 802. Defendant's attorneys made the hearsay argument in response to plaintiff's attorneys' contention that defendant hospital's incident reports should be admitted as routine business records, as exception to the hearsay rule.

Hearsay Exceptions; Availability of Declarant Immaterial

The following are not excluded by the hearsay rule, even though the declarant is available as a witness:

. . . .

Records of regularly conducted activity.

A memorandum, report, record, or data compilation, in any form, of acts, events, conditions, opinions, or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge, if kept in the course of a regularly conducted business activity, and if it was the regular practice of that business activity to make the memorandum, report, record, or data compilation, all as shown by the testimony of the custodian or other qualified witness, unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness. The term "business" as used in this paragraph includes business, institution, association, profession, occupation, and calling of every kind, whether or not conducted for profit.

FED. R. EVID. 803(6).

Modern courts, however, generally admit medical records under the business records exceptions to the hearsay rule. Courts may also admit hospital incident reports into evidence under the same rationale, although hospital attorneys argue earnestly that they are only prepared in *unusual* circumstances. *See, e.g.*, Sims v. Knollwood Park Hosp., 511 So. 2d 154 (Ala. 1987) (denying attorney-client privilege for incident reports prepared routinely whenever litigation was anticipated, not for specific litigation); Kay Labs., Inc. v. Dist. Ct., 653 P.2d 721 (Colo. 1982) (hospital reports made for insurance company on its form within hours of incident held discoverable).

However, some courts have held that hearsay statements made in the course of business which do not relate to the treatment or medical history of a patient are not admissible. *See, e.g.*, Commonwealth v. Hosey, 359 N.E.2d 1316, 1319 (Mass. App. 1977); Mikel v. Flatbush Gen. Hosp., 370 N.Y.S.2d 162, 165 (1975) (holding that third parties' opinions as to how a patient's accident occurred, although noted in the medical record, were inadmissible hearsay). *See also* Picker X-ray v. Frerker, 405 F.2d at 922, (incident reports are "hospital records . . . which qualify as business records [citations omitted] but have no relationship to future treatment of the particular patient" and are, therefore, privileged). The general rule is that the more opinions the hospital documentary evidence contains, the less reliable it is, even if it is routinely prepared.

"[T]here is a point at which opinion evidence . . . as to how accidents occurred will be objectionable." Skogen v. Dow Chem. Co., 375 F.2d 692, 704 (8th Cir. 1967) (overruled by *Manko v. U.S.*, 636 F. Supp. 1419 (W.D. Mo. 1986)). *See also* Picker X-ray, 405 F.2d at 922-23 (remarking that the incident report is less reliable than other medical records because it does not pertain to future treatment).

In the modern hospital, incident reports are *routinely* prepared in response to both the external pressure from insurers and hospital accreditation authorities such as JCAHO. *See*

they are not privileged attorney work product.[48] Applying the doctrine of privilege to incident reports, however, would preserve both

supra notes 22-23 and accompanying text for a reference to routine preparation of incident reports. They are also mandated by the internal pressure of management and quality assurance auditors and committees. *See* FIESTA, *supra* note 15 at 174-75, COURNOYER *supra* note 17; GUIDO, *supra* note 16, at 104-5 (discussing uses of incident reports for internal risk management and quality assurance and for external legal loss control). Incident reports, therefore, neatly fit within the business records exception to the hearsay rule and so generally they are treated like an admission for evidentiary purposes.

Because cases denying admissibility to incident reports under the hearsay argument are the exception to the rule, the hearsay rule does not offer the guarantee of confidentiality necessary to promote the degree of open communication essential to making hospital incident reports useful in improving the quality of care and reducing hospital losses. Unless a special privilege is created to protect them, or they are denied admission because they are offered as evidence of negligence because their purpose is to implement corrective measures, uncertainty persists as to whether or not hospital incident reports are admissible and uncertainty discourages full disclosure.

48. Recently, courts have rejected a work product immunity theory and have begun to allow the discoverability of hospital incident reports. Work product immunity is a qualified privilege which protects trial preparation materials from discovery. *See* Hickman v. Taylor, 329 U.S. 495 (1947). The burden of proof is on the party requesting discovery to demonstrate "substantial need" for the *factual* materials discovered by the attorney, and to demonstrate that obtaining the materials from any other source would be extremely difficult ("undue hardship") before the court will compel discovery. FED. R. CIV. P. 26(b)(3); *See Hickman*, 329 U.S. at 511-12; *see, e.g.*, Bird v. Penn Central Co., 61 F.R.D. 43, 46 (E.D. Pa. 1973) (finding that the attorney's work product was discoverable because substantial need and an inability to obtain its equivalent by other means was shown by the moving party); *see also* Stephen McG. Bundy & Einer R. Elhauge, *Do Lawyers Improve the Adversary System?*, 79 CAL. L. REV. 313, 401 (1991). *But see* Kevin M. Clermont, *Surveying Work Product*, 68 CORNELL L. REV. 755, 758-59 (1983); Thomas W. Hyland & Andrea E. Forman, *The Corporate Attorney-Client Privilege*, N.Y. STATE BAR J., Dec. 1990 at 17, 17 (discussing the higher threshold for opinion and "strategy" information).

Rule 26(b)(3) of the *Federal Rules of Civil Procedure* states:

> A party may obtain discovery of documents and tangible things otherwise discoverable . . . and prepared in anticipation of litigation or for trial by or for another party or by or for that party's representative (including the other party's attorney, consultant, surety, indemnitor, insurer, or agent) only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the party's case and that the party is unable without undue hardship to obtain the substantial equivalent of the materials by other means. In ordering discovery of such materials when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or other representative of a party concerning the litigation.

FED. R. CIV. P 26(b)(3) (codifying the definition of work product as established in Upjohn v. United States, 449 U.S. 383, 397-98 (1981)). The *Hickman* court had included both tangible and intangible probative information such as the attorney's thoughts. 329 U.S. at 497. Some commentators literally interpret Rule 26(b)(3) to require a three-part test to be met before information meets the definition of work product. Jeff A. Anderson et al., Note, *The Work Product Doctrine*, 68 CORNELL L. REV. 760, 792 (1983). "The materials must be: 1. 'documents and tangible things'; 2. 'prepared in advance of litigation or for trial'; and 3. 'by or for another party or for that other party's representative.' " *Id.* A majority of courts utilize some form of this three-pronged test in analyzing whether an incident report is work product. *See, e.g.*, Payne v. Howard, 75 F.R.D. 465 (D.D.C. 1977); Hospital Corp. of America v. Dixon, 330 So. 2d 737 (Fla. 1976); Sims v. Knollwood, 511 So. 2d 154 (Ala. 1987); Kay Labs.

of the beneficial objectives of the incident report: alerting the attor-

v. District Court, 653 P.2d 721 (Colo. 1982); State *ex rel.* Faith Hosp. v. Enright, 706 S.W.2d 852 (Mo. 1986).

Defendants' attorneys have difficulty arguing that incident reports fit the three-pronged test. An incident report is a tangible document, often a preprinted form provided by the hospital attorney or insurer, which readily meets the first prong. However, courts have differed on the interpretation of the second and third prongs of the test. *See, e.g.,* White v. New York City Health & Hosps. Corp., No. 88 Civ. 7536, 1990 U.S. Dist. LEXIS 3008 (S.D.N.Y. 1990) (finding that a preprinted incident report form was discoverable); Enke v. Anderson, 733 S.W.2d 462, 465 (Mo. 1987) (finding that a preprinted incident report form was privileged).

The second prong of the work product privilege test is that the prospect of litigation must be real and imminent. *See* Stephen A. Saltzburg, *Corporate and Related Attorney-Client Privilege Claims*, 12 HOFSTRA L. REV. 279, 306 n. 130 (1984) (citing United States v. Davis, 636 F.2d 1028, 1040 (5th Cir. 1981), *cert. denied,* 454 U.S. 862 (1981); and *In re* Special September 1978 Grand Jury (II), 640 F.2d 49, 65 (7th Cir. 1980)); *see also Sims,* 511 So.2d at 157. Liberal interpretation suggests that incident reports *are* prepared in anticipation of litigation or for trial because they are prepared in response to an event which is likely to trigger suit. *See* MONAGLE, *supra* note 22 at 29; Puetz, *supra* note 27, at 245 (discussing the purposes of incident reports). Courts have required different degrees of likelihood of litigation for this second prong. Some courts find that parties must merely meet a proximity requirement. *See Sims,* 511 So.2d at 157 (quoting Diversified Indus., Inc. v. Meredith, 572 F.2d 596, 604 (8th Cir. 1977) ("the work product rule does not come into play merely because there is a remote prospect of future litigation")). The proximity test as defined in 8 CHARLES A. WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE & PROCEDURE § 2024 (1969) is "whether, in light of the nature of the document and the factual situation in the particular case, the document can fairly be said to have been prepared or obtained [by the attorney] because of the prospect of litigation." Other courts have held that an actual claim must already have been made against the defendant. *See Kay Labs.*, 653 P.2d at 722 (in denying work product privilege to a hospital incident report prepared after a patient was chemically burned by a defective ice pack, the court declared that privileged material must be prepared with specific litigation in mind). The timing of the litigation, therefore, may be crucial to a privilege argument under work product theory.

Another difficulty in determining whether or not the incident report can meet the second prong of the work product immunity test is whether preparation for litigation is the sole purpose of the report. Incident reports serve another purpose in addition to informing the attorney. For example, reports which serve both a business function in the routine course of hospital activities (risk management and quality assurance could be considered part of hospital routine) and a legal function to alert the attorney to possible future litigation have been denied the work product privilege by some courts. *See, e.g.,* Clark v. Norris, 734 P.2d 182 (Mont. 1987) (denying hospital incident reports be automatically privileged due to their dual purpose: trial preparation and internal risk management). Some courts insist upon a singular purpose for the incident report; it may only be prepared in anticipation of a legal claim, not for quality assurance functions. *See* Sierra Vista Hosp. v. Shaffer, 56 Cal Rptr. 387, 388 (1967) (citing D.I. Chadbourne, Inc. v. Superior Court, 388 P.2d 700, 737 (Cal. 1964) (holding where there is more than one intended purpose for the report, the "dominant purpose" will determine whether or not it is privileged)). Therefore, the second prong presents two hurdles: the imminence of litigation and the singularity of purpose.

The third prong of the work product privilege test is also a stumbling block. Some courts have held that incident reports may meet the third prong because they are prepared for the health care provider's representative, including some or all of the following: the insurer's counsel, in-house counsel, the risk management consultant, and the quality assurance consultant. *See, e.g., Sierra Vista Hosp.*, 56 Cal Rptr. at 387; *Enke*, 733 S.W.2d at 466;

ney of potential problems which could generate a lawsuit and alerting those responsible for improving health care standards of situations they can work to correct.[49]

MONAGLE, *supra* note 22, at 28. However, courts have not universally agreed that incident reports meet the third prong representative requirement. For example, the Alabama Supreme Court rejected the hospital defense attorney's work product theory in *Sims v. Knollwood*. This case involved a patient who sustained a hip fracture after a fall from his bed. The Court applied the arguments of the landmark work-product doctrine case, *Hickman v. Taylor*, to deny privilege for the incident report. *Sims*, 511 So. 2d at 157. (citing Hickman v. Taylor, 329 U.S. 495 (1947)). "The written statement of a witness, whether prepared by him and later delivered to the attorney, or drafted by the attorney and adopted by the witness, is not properly considered the 'work product' of an attorney. It records the mental impressions and observations of the witness himself and not those of the attorney." Scourtes v. Fred W. Albrecht Grocery Co., 15 F.R.D. 55, 58 (N.D. Ohio 1953).

Courts and legal scholars have difficulty in establishing threshold qualifications to determine which of the various tangible and intangible materials should be immunized from discovery. *See* Clermont, *supra*, at 762-763 (declaring that "work product protection is the most frequently litigated discovery issue" as a consequence of its ambiguity). The presumption favors discoverability and most "courts and commentators generally agree that the privilege should be narrowly interpreted." Gwenn Mayers, *The Second Circuit Restricts Evidentiary Privileges for Corporate Communications* 49 BROOK L. REV. 1103, 1105 (1983). In other corporate contexts, the courts have been more liberal in balancing the substantial hardship of the opposing party against the defense attorney's desire to protect the materials. *See* Moldovan, *supra* at 828. Even the more liberal courts, however, have implied that different materials would more likely be privileged such as the attorney's own impressions from the interviews. *Id.* Further, his internal memoranda are more likely to be privileged than "questionnaires filled out in the employee's own words." *Id.* The presumption always favors discovery for the policy reasons enunciated in *Hickman v. Taylor*. "We agree . . . that the deposition-discovery rules are to be accorded a broad and liberal treatment. . . . Mutual knowledge of all the relevant facts gathered by both parties is essential to proper litigation," Caroline T. Mitchell, Note, *The Work Product Doctrine in Subsequent Litigation*, 83 COLUM. L. REV. 412, 414 (1983) (quoting *Hickman*, 329 U.S. at 507). Although this undercuts the case for hospital incident report privilege, since hospital incident reports are often in questionnaire format, the format and standards for preparation of the reports could be, and their primary purposes remain in notifying the hospital attorney of potential litigation and improving the quality of health care. *See infra* Sec. IV. A-1.

Because of the difficulties courts create by narrowly and inconsistently interpreting the three prong test of work product privilege, health care workers are unable to determine with certainty whether incident reports will be privileged or not. Hospital employees cannot know in advance how likely litigation will be, so they cannot depend on work product immunity to protect what they reveal in the incident reports. Full disclosure of information is inhibited by the uncertainty. Work product immunity, however, is not the best argument for keeping incident reports out of the hands of plaintiff's attorneys. Attorney-client confidentiality and health care enhancement are.

49. *See* Sherman L. Cohn, *The Work Product Doctrine: Protection Not Privilege*, 71 GEO. L. J. 917, 919 (1983) (discussing two important goals of the adversary system which would be thwarted by compelled discovery: "full preparation and zealous advocacy"). The hospital attorney's ability to prepare for potential claims so that she may zealously defend her client the hospital is impaired if she is not alerted to the problem by an incident report prepared soon after the event occurred. The attorney's advice may not be effective if it is based on retrospective or incomplete accounts of events, and the hospital may be subject to further liability if the same incidents continue to occur.

III. TWO COMPELLING ARGUMENTS FOR HOSPITAL INCIDENT REPORT PRIVILEGE: ATTORNEY-CLIENT CONFIDENTIALITY AND HEALTH CARE QUALITY IMPROVEMENT

Privileges between attorney and client are necessary when there is a strong societal interest in encouraging "clients to make full disclosure to their attorneys,"[50] such as the interest in seeking the attorney's advice about whether the circumstances surrounding the incident place the hospital at a liability risk. Privileges are often differentiated by the discoverabilty (what is privileged from pretrial discovery) and admissibility (what is privileged from admission into evidence at trial),[51] but once privilege from discovery is established, it follows that the hospital incident report will be inadmissible because discoverability is the threshold for admissibility.[52] This Note

50. *See* Fisher v. United States, 425 U.S. 391, 403 (1976) (quoted in Upjohn v. United States, 449 U.S. 383, 389 (1981)); Marshall Williams, *The Scope of Attorney-Client Privilege in View of Reason and Experience*, 25 How. L.J. 425, *supra* note 48 at 436 n.53 (1982) (noting that the public policy of protecting confidential communications is too well-known to need extended comment). *But see,* Mitchell, *supra* note 48 at 415 (declaring that privileges "do not in any wise aid in the ascertainment of truth, but rather they shut out the light. Their sole warrant is the protection of interests and relationships which, rightly or wrongly, are regarded as of sufficient social importance to justify some incidental sacrifice of sources of facts needed in the administration of justice") (quoting CHARLES T. MCCORMICK, *The Scope of Privilege in the Law of Evidence*, 16 TEX. L. REV. 447, 447-48 (1938)). This note does not defend the utility of privilege in general, but assumes that since they have proved to be valuable in some contexts they will be useful in the health care context as well.

51. B. Abbott Goldberg, *The Peer Review Privilege: A Law In Search of a Valid Policy*, 10 AM. J. L. & MED. 151, 153 (1984) (quoting FED. R. CIV. P. 26(b)(1): "the general rule [is] that discovery is not limited to admissible evidence but rather extends to the discovery of information that is 'reasonably calculated to lead to the discovery of admissible evidence.' Conversely, the fact that records are privileged from pretrial discovery does not require that they be excluded at trial"). This was a critical distinction made by Florida statutes governing privilege for risk management activities such as incident report preparation: "incident reports 'shall be subject to discovery, but shall not be admissible as evidence in court.'" Tallahassee Memorial Medical Ctr. v. Meeks, 560 So. 2d 778 (Fla. 1990) (quoting FLA. STAT. ANN. § 395.041(4) (1990)).

52. Discovery Scope and Limits.

Unless otherwise listed by order of the court in accordance with these rules, the scope of discovery is as follows:

(1) *In General.* Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

argues for two distinct but individually valid privileges: the attorney-client privilege[53] and a proposed quality assurance privilege utilizing the peer review privilege model[54] and the subsequent repair rule.[55]

A. Attorney-Client Privilege

Attorney-client privilege, the "oldest of the interpersonal communication privileges,"[56] is a frequently-invoked argument favoring privilege for hospital incident reports.[57] Two main philosophies support this privilege: the utilitarian theory[58] and the rights approach.[59] The utilitarian theory espouses a balancing test which pits the societal benefit of non-disclosure against the harm to the judicial fact-finder.[60] The rights approach holds that in some instances it is simply wrong to compel theses types of confidential communications because of the importance of preserving the right of the parties to believe that what they communicate to their attor-

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FED. R. CIV. P. 26(b)(1).

53. Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

FED. R. EVID. 501.

54. *See infra* § III(B)(1) for discussion of the medical peer review committee privilege.

55. Subsequent remedial measures

When, after an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence or culpable conduct in connection with the event. This rule does not require the exclusion of evidence of subsequent measures when offered for another purpose, such as proving ownership, control, or feasibility of precautionary measures, if controverted, or impeachment.

FED. R. EVID. 407.

56. Note, *Developments—Privileged Communications*, 98 HARV. L. REV. 1450, 1501 (1985).

57. *See e.g.*, Sims v. Knollwood Park Hosp., 511 So. 2d 154, 156 (Ala. 1987); Clark v. Norris, 734 P. 2d 182, 186 (Mont. 1987); Enke v. Anderson, 733 S.W. 2d 462, 464 (Mo. App. 1987); State ex rel. Children's Medical Ctr. v. Brown, 571 N.E. 2d 724, 726 (Ohio 1991); *In re* Death of Francis v. St. Thomas Hosp., No. 8556, slip op. (Ohio Ct. App. Dec. 7, 1977).

58. *See* Michael L. Waldman, *Beyond* Upjohn: *The Attorney-Client Privilege in the Corporate Context*, 28 WM. & MARY L. REV. 473, 479 (1987).

59. *See* Note, *supra* note 56, at 1501 n.6.

60. *See* Waldman, *supra* note 58, at 479. For further description of the utilitarian approach to attorney-client privilege, *see* Note, *supra* note 56, at 1502.

neys will remain confidential.[61]

The attorney-client privilege is absolute and protects only the confidential communications between the client and the attorney.[62] It "is designed to 'facilitate the administration of justice' by encouraging full and open communications between the client and the attorney."[63] Because it is absolute, the attorney-client privilege may only be invoked when certain criteria are met.[64] Some state courts have applied stringent "prerequisites" for the attorney-client privilege.[65] For example, in Louisiana, as in most jurisdictions, to meet the attorney-client privilege test, there must be an established relationship between the attorney and the client, the communication must have been given in confidence, and the communication must be "sufficiently connected to the subject matter of the attorney's representation."[66]

The fact that the communication went to a number of persons sometimes defeats the attorney-client privilege. Some courts have ruled that incident reports are not confidential communications because they are made under the direction of the hospital's internal administration, not just the attorney, and the reports are delivered to hospital administrators and insurers.[67] Courts denying attorney-client privilege to hospital incident reports have also declared that there can be no communication until it has been received by the

61. *See* Note, *supra* note 56, at 1501 n.3 (citing 91 HARV. L. REV. 464, 465 (1977) and 2 D. LOUISELL & C. MUELLER, FEDERAL EVIDENCE § 201, at 417 (1978)).

62. Mayers, *supra* note 48, at 1103.

63. Mayers, *supra* note 48, at 1104-05 (citing Natta v. Hogan, 392 F. 2d 686, 691 (10th Cir. 1968); citing Hunt v. Blackburn, 128 U.S. 464, 470 (1888)).

64. *See* Richard L. Marcus, *The Perils of Privilege: Waiver & The Litigator*, 84 MICH. L. REV. 1605, 1605 (1986) (citing 8 J. WIGMORE, EVIDENCE IN TRIAL AT COMMON LAW § 2292, at 554 (J. McNaughton ed. 1961):

> (1) Where legal advice of any kind is sought (2) from a professional legal advisor in his capacity as such, (3) the communications relating to that purpose, (4) made in confidence (5) by the client, (6) are at his instance permanently protected (7) from disclosure by himself or the legal advisor, (8) except the protection be waived.

See also, Merton E. Marks, *The Attorney-Client Privilege and the Work Product Doctrine in the Corporate Setting*, F.I.C.C. Q., Fall 1990 (stated five elements required to establish the attorney-client privilege).

65. *See e.g.*, Robert Force & Kerry J. Triche, *The Current State of Evidentiary Privileges in Louisiana*, 49 LA. L. REV. 733, 752 (1989) (though making reference to criminal standards, the author describes little more flexibility in the civil standard).

66. *Id.* at 752-53.

67. *E.g., In re* Death of Francis, *supra* note 57 (holding that the incident reported was not privileged as a confidential attorney-client communication although hospital personnel made the incident report immediately after the death of the patient and forwarded it to a hospital director, who photocopied and only disbursed it to two hospital attorneys); Bernardi v. Community Hosp. Ass'n, 443 P. 2d 7080, 715-16 (Colo. 1968) (unsuccessfully arguing for attorney-client privilege for hospital incident reports).

attorney.[68] Other courts have accepted hospitals' arguments that because the reports are not included in the medical record, and are oftentimes forwarded directly to the hospital's or malpractice insurance carrier's attorney, or both, the reports constitute confidential communication between the hospital and its lawyers.[69] This is the better view, because otherwise the hospital might choose to give it only to the attorney, foiling the quality improvement purpose to preserve the attorney-client privilege.

The attorney-client privilege argument for hospital incident reports is modeled on corporate attorney-client privilege cases. The corporate attorney-client privilege developed because the pure attorney-client privilege protected from compelled disclosure only confidential communications between the *client* and the lawyer; it did not extend to information the attorney obtained from other parties.[70] Where a corporation is the client, uncertainty exists as to whose communication is protected.[71]

Courts have formulated various tests to determine who is a privileged party.[72] Formerly courts restricted privilege to the "control group," the corporation's managers and executives with authority to direct corporate activity.[73] The focus of the control test was on privilege for the individuals who personified the corporation,[74] as opposed to treating the corporation as the privileged person. However, the control group test stifled open communication between lower level employees and the corporation's attorney because any such information could be used against these employees to demon-

68. Bernardi, 443 P. 2d at 715-16. There could be no privileged communication without receipt of the communication by the attorney.

69. *See, e.g.*, Sierra Vista Hosp. v. Shaffer, 56 Cal. Rptr. 387 (1967) (applying Cal. Civ. Proc. Code §§ 2031, 2016(b); Cal Evid. Code § 952); Sligar v. Tucker, 267 So. 2d 54 (Fla. Dist. Ct. App. 1972) (two cases successfully arguing for attorney-client privilege for hospital incident reports).

70. *See* Bundy & Elhauge, *supra* note 48.

71. *See* Note, *The Attorney-Client Privilege and the Corporate Client: Where Do We Go After* Upjohn?, 81 MICH. L. REV. 665, 667-68 (1983); Saltzburg, *supra* note 48, at 280-81 (discussing the two competing approaches for determining whose communications are privileged); Williams, *supra* note 50, at 439 (noting the difficulties in ascertaining whose communications on behalf of the corporation are privileged).

72. *See, e.g.*, Waldman, *supra* note 58; Williams, *supra* note 50; Note, *supra* note 56; Saltzburg, *supra* note 48; Marks, *supra* note 64 (discussing the various corporate attorney-client privilege tests).

73. *See* Marks, *supra* note 64, at 86 n.7; Hyland & Forman, *supra* note 48, at 18 (discussing Philadelphia v. Westinghouse Elec. Corp., 210 F. Supp 483 (E.D. Pa. 1962)).

74. Upjohn Co. v. United States, 449 U.S. 383, 390 (citing General Elec. Co. v. Kirkpatrick, 312 F. 2d 742 (3rd Cir. 1962), cert. denied 372 U.S. 943 (1963)).

strate personal liability.[75] Since the control group test focused on who was communicating rather than the subject matter of the communication, it undercut the policies underlying privilege.[76]

The "subject matter" test, on the other hand, extends the privilege vertically to other corporate employees in addition to upper management.[77] The test creates an agency privilege and encourages disclosure of all information necessary for legal decision-making as long as the employee is directed by his superiors to make the confidential communication, and the subject matter of the communication is within the scope of the employee's duties.[78] Although the subject matter test does not restrict the discovery of ordinary business records,[79] courts have criticized its potential for creating a "zone of silence" when corporate managers direct employees to filter all sensitive information through the attorney.[80]

The *Duplan* test, a hybrid of the control group and subject matter tests, limits privilege to the control group, but extends the control group to include "any corporate employee, agent or representative involved in rendering information necessary to the decision-making process regarding [a particular] problem."[81] The *Duplan* requirements differ from the subject matter requirements in that the person communicating with the attorney does not have to be doing so within the scope of employment duties.[82] The *Duplan*

75. *See, e.g.*, Saltzburg, *supra* note 48, at 281.

76. *See* Williams, *supra* note 48, at 441. *See also* Waldman, *supra* note 58, at 485 for a discussion of the Hobson's Choice corporate attorneys faced under the control group test.

77. *See* Hyland & Forman, *supra* note 48, at 18. The requirements for subject matter corporate attorney-client privilege are: "(1) the communication must be made for the purpose of securing legal advice; (2) the employee making the communication must do so at the direction of his superior; (3) the direction was given by the superior to obtain legal advice for the corporation; (4) the subject matter of the communication must be within the scope of the employees corporate duties and (5) the communication is not disseminated beyond those persons who need to know." *Id.* (citing *Diversified Industries, Inc. v. Meredith*, 572 F.2d 596, 609 (8th Cir. 1978) (en banc)). The subject matter test is also referred to as the scope of employment test and the Harper & Row test. Saltzburg, *supra* note 48, at 289; Williams, *supra* note 50, at 243.

78. Williams, *supra* note 50, at 442.

79. Hyland & Forman, *supra* note 48, at 18.

80. *See* Note, *supra* note 71, at 676 n.38 (citing United States v. El Paso Co., 682 F. 2d 530, 541 (5th Cir. 1982); Susan A. Moldovan, *The Attorney-Client Relationship in the Corporate Organization*, 46 BROOK. L. REV. 803, 809 (1980) (discussing the abuses that result from a broad application of the privilege. *See also* Diversified Indus., Inc. v. Meredith, 572 F. 2d 596 (8th Cir. 1978) (applying a modified *Harper and Row*, *supra* note 77, subject-matter test to determine whether communication is protected by attorney-client privilege).

81. Williams, *supra* note 50, at 444-45 (emphasis omitted) (discussing the test applied in Duplan Corp. v. Deering Milliken, Inc., 397 F. Supp 1146, 1165 (D.S.C. 1974).

82. Williams, *supra* note 50, at 446.

test avoids the broad "zone of silence" created by the subject matter test, because only communications related to the specific legal problem at issue are privileged.[83] Since the *Duplan* test focused on the particular problem, not the status of the particular person providing the information about it, more low-level personnel are encouraged to communicate with the attorney.[84]

The "modified subject matter" test, as defined by the Eighth Circuit in *Diversified Industries, Inc. v. Meredith*,[85] predicates corporate attorney-client privilege on more restrictive standards than the subject matter/scope of employment test.[86] The corporate employee's confidential communication must meet the following conditions for the attorney-client privilege to apply:[87]

> (1) the communication was made for the purpose of securing legal advise; (2) the employee making the communication did so at the direction of his corporate superior; (3) the superior made the request so that the corporation could secure legal advice; (4) the subject matter of the communication is within the scope of the employee's corporate duties; and (5) the communication is not disseminated beyond those persons who, because of the corporate structure, need to know its contents.[88]

Although it has been praised for narrowing and clarifying the attorney-client privilege, the modified subject matter test has been criticized for thwarting the purpose of privilege.[89] Lower-level employees will not be free to disclose information to the attorney unless they have been commanded to do so by their superiors; if the communication may only be made for the purpose of securing legal advice, the scope of the information revealed will also be limited.[90]

None of the tests resolves all the differences of interpretation about which communications qualify for the attorney-client privilege. In the *Upjohn* case, the Supreme Court expressly denounced the "control group" standard, but did not recommend a preferred

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83. *Id.*

84. *Id.* at 445.

85. 572 F. 2d 596, 609 (8th Cir. 1978). *See* Note, *supra* note 71, at 676.

86. *See* Williams, *supra* note 50, at 446-49 (discussing what it labelled as the "Modified Harper & Row Test"); Note, *supra* note 71, at 676-83; *see also* Saltzburg, *supra* note 48, at 290-91 (stating "[t]he court endeavored to restate the scope of employment test to assure that the privilege did not provide corporations with a device to hide information under the guise of seeking legal advice").

87. *See* Note, *supra* note 71, at 677 n.43.

88. Meredith, 572 F. 2d at 609 (citing WEINSTEIN & M. BERGER, 2 WEINSTEIN'S EVIDENCE § 503(b)(04) (1975)).

89. *See* Note, *supra* note 71, at 677.

90. *Id.*

alternative test for corporate attorney-client privilege.[91] *Upjohn* suggested a case-by-case analysis to determine which communications by which persons in the corporate context are privileged;[92] however, the unpredictable outcome of this approach undermines uninhibited disclosure.[93]

Courts have applied the corporate attorney-client privilege tests to hospital incident reports, with varying outcomes.[94] For example, in *Enke v. Anderson*[95], the Missouri appellate court held that an incident report prepared by a nurse to document the fall of an unattended patient who had just been medicated was privileged from discovery though it was sent to the hospital's insurer.[96] After analyzing the mixed precedent within the jurisdiction,[97] the court utilized a standard much like the *Duplan* test, declaring that "[t]he hospital, as an insured, could act only through its employees."[98] In *Clark v. Norris*,[99] the Montana Supreme Court denied attorney-client privilege to an incident report prepared by an operating room nurse to document that a patient sustained a perforated uterus and intestinal damage during a routine dilation and curettage ("D and C").[100] The *Clark* court rejected the subject matter, *Duplan*, and modified subject matter tests, proclaiming that it did not matter that the report was made at the direction of the corporation and that its subject matter was within the scope of the maker's employment; the significant factor in determining whether the privilege applies, in the court's view, is the *purpose* of the report.[101] The court was not convinced that the incident report in question was intended

91. Upjohn Co., *supra* note 48, at 393-97.

92. *Id.* at 396.

93. *See* Waldman, *supra* note 58; Note, *supra* note 71 (discussing the lack of certainty as to a corporate attorney-client privilege standard after *Upjohn*).

94. *See* Ellen K. Murphey, *Incident Reports May or May Not Be Privileged Information*, 51 AORN (Am. Operating Room Nurses) Journal 851 (1990) (illustrating how different states reach different conclusions).

95. 733 S.W. 2d 462 (Mo. Ct. App. 1987).

96. *Id.* at 469.

97. The *Enke* court adopted the pro-attorney-client privilege status accorded incident reports in State ex rel Cain v. Barker, 540 S.W. 2d 50 (Mo. 1976) and May Dept. Stores Co. v. Ryan, 699 S.W. 2d 134 (Mo. Ct. App. 1985) after distinguishing the anti-incident report privilege opinions of State ex rel Faith Hosp. v. Enright, 706 S.W. 2d 852 (Mo. 1986) and St. Louis Little Rock Hosp., Inc. v. Gaertner, 682 S.W. 2d 146 (Mo. Ct. App. 1984). Enke, 733 S.W. 2d at 465-68.

98. Enke, 733 S.W.2d at 468.

99. 734 P.2d 182 (Mont. 1987).

100. *Id.* at 184.

101. *Id.* at 187 (citing Sierra Vista Hosp. v. Superior Ct. 56 Cal. Rptr. 387, 392 (1967)). The Colorado court also emphasized the singular *purpose* requirement in Bernardi v. Community Hosp. Ass'n, 443 P.2d 708, 710 (Colo. 1968).

to be a confidential communication to the hospital attorney prepared in anticipation of litigation, because it served *dual* purposes: internal quality control and preparation of litigation.[102]

Because courts adopt different attorney-client privilege tests, and apply these tests inconsistently to hospital incident reports, health care workers cannot be certain that what they disclose in incident reports will be kept confidential. When the reports serve more than one purpose, even if both purposes serve important policies, the privilege is uncertain. Consequently, hospital employees, may choose not to reveal useful information to hospital attorneys, liability insurers, risk managers and quality assurance personnel. Or, they may choose to reveal it only to the attorney, defeating the quality improvement purpose. Either way, unpredictability of attorney-client privilege for hospital incident reports will produce the same results as no privilege ar all. Uncertainty will deter hospital employees from full disclosure of information which could be used to assist the attorney in advising the hospital to prevent future losses.

B. Quality Assurance Privilege

As important as the policies for attorney-client privilege for hospital incident reports are, the justifications for a quality assurance privilege are even more compelling. Quality assurance personnel need to know witness' impressions and opinions about accidents and potentially dangerous situations to increase efficiency and safety among the staff and the overall quality of care for patients and visitors, just as attorneys need to know the same information to reduce hospital losses from lawsuits. Generally, the quality assurance committee of a hospital consists of the hospital's in-house counsel, doctors and nurses from various specialties, pharmacy and maintenance/engineering representatives, and a professional risk manager with liability insurance education.[103] The quality review process allows trained personnel to analyze incident report data for negative trends and to make recommendations to hospital employees who work directly in the particular areas where the problems are. These people closest to the situation can implement corrective action based on dispassionate criticism. The quality assurance com-

102. Clark, 734 P.2d at 187.

103. *See* JOINT COMMISSION MANUAL FOR ACCREDITATION OF HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL (1992) (listing the composition of the quality improvement committee); CARROLL, *supra* note 30 (discussing who typically serves on the committees).

mittee's work benefits hospital staff because it provides them with useful feedback to improve their skill. Neutral evaluators often identify problems and solutions more readily than those who work in the problem areas because they independently review a variety of data and incident reports. The quality monitoring and improvement process is much more effective if the information sent to the committee is candid and thorough. Health care workers are much more likely to provide complete incident reports if they are certain that the information will be kept confidential by the quality assurers, much as information used in medical peer review committees is kept confidential by members of those committees.

1. Medical Peer Review Committee Privilege:

The medical peer review committee privilege protects physicians who evaluate each other from defamation liability.[104] The peer review privilege has been almost universally recognized by the courts, and is statutorily mandated in some states.[105] Because candor is essential to the physicians' evaluation process, and states have a compelling interest in ensuring a high standard of professionalism in the medical community,[106] states created statutes to protect the confidential communications of health care personnel in the review process.[107] The medical peer review committee has been broadly defined to include:

> a committee . . . of a medical staff of a licensed hospital or nursing home. . .which committee has as its function the evaluation or improvement of the quality of health care rendered by providers of health care services . . . were performed in compliance with

104. *See* Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970) (noting the purpose of peer review privilege in encouraging professional criticism).

105. *See, e.g.*, Hendrickson v. Leipzig, 715 F. Supp. 1443 (E.D. Ark. 1989); Laws v. Georgetown Univ. Hosp., 656 F. Supp. 824 (D.D.C. 1987); Bredice v. Doctor's Hosp., Inc., 157 F.R.D. 187 (D.D.C. 1970); Shelton v. Morehead Memorial Hosp., 347 S.E. 2d 824 (N.C. 1986); statutes: ARK. CODE ANN. § 16-46-105 (Michie 1990); N.C. GEN. STAT. tit. 5 § 131E-76(5) (1992) (North Carolina Hospital Licensure Act); FLA. STAT. ANN. § 395.011(a) (West 1986 & Supp. 1988); MICH. STAT. ANN. § 14.15(21513) (1986); CAL. EVID. CODE § 1157; ILL. REV. STAT. 1985, ch. 110, para. 8—2101; N.Y. CIV PRAC. L. & R. § 3101 (Console 1991); KAN. STAT. ANN. § 65-4915 (1990); OHIO REV. CODE ANN. § 23205.251 (Baldwin 1991). *See generally*, Charles D. Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C.L. REV. 179 (1988) (discussing the recognition and application of the peer review committee privilege as adopted by 46 different states).

106. *See* Dorsten v. Lapeer County Gen. Hosp., 88 F.R.D. 583, 585-86 (E.D. Mich. 1980) (quoting Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970). The *Bredice* court declared that "candid and conscientious evaluation of clinical practices is the *sine qua non* of adequate health care." *Id.*

107. *See* Creech, *supra* note 105, at 185-86.

> the applicable standards of care, the determination whether the cost of health care services rendered . . . was considered reasonable by the providers of health services in the area, the determination of whether a health care provider's actions call into question such health care provider's fitness to provide health care services, or the evaluation and assistance of health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical disability, mental instability or otherwise.[108]

Committees with these functions include "Patient Care Audit Committees, Medical Care Evaluation Committees, Utilization Review Committees, Credential Committees, and Executive Committees."[109] The rationales for maintaining the confidentiality of communications made in peer review committees by physicians evaluating their colleagues are the same rationales hospital attorneys use to argue for incident report privilege: the need for open and honest assessment of practices and procedures to promote better health care without risk of personal liability.[110] Peer review activities for quality assurance purposes are required by law for hospitals receiving federal reimbursement.[111] Accrediting agencies, such as JCAHCO, also require peer review by medical staff as a condition for accreditation.[112] Some states statutorily mandate peer review activities for quality assurance and risk management.[113] The ultimate goal of these statutes, reimbursement requirements, and accrediting regulations, in every case, is improvement of patient care.[114]

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108. MASS. GEN. LAWS ANN., ch. 111 § 1 (West 1986).

109. ILL. REV. STAT. ch. 110, para. 8—2101 (1992).

110. *See* Creech, *supra* note 105, at 179; Goldberg, *supra* note 51, at 151; Niven v. Siqueira, 487 N.E.2d 937, 942 (1985) (noting the objective of statutory peer review privilege "is to encourage candid voluntary studies and programs used to improve hospital conditions and patient care or to reduce the rates of death and disease").

111. 42 U.S.C.A. §§ 1395x(e), 1395(k) (West 1982 & Supp. 1992).

112. *See* JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL FOR HOSPITALS, Standards MS.1, MS.6 (1990).

113. *See, e.g.*, MASS. GEN. LAWS, ch. 112 § 5 (1986) (placing an " 'affirmative duty' on each health care provider to report 'injuries and incidents' to the facility's Patient Care Assessment Coordinator." (cited in Beth Israel Hosp. Ass'n v. Board of Registration in Medicine, 515 N.E.2d 574, 575 (Mass. 1987)); WASH. REV. CODE, ch. 70.41.230 (1990); FLA. STAT. ANN. § 395.011 (West 1986 & Supp 1983); MICH. STATE. ANN. § 14.15(21513) (Callaghan 1988); NEB. REV. STAT. § 71-2046 (1990).

114. Because it provides an absolute shelter to physicians from defamatory liability (*see, e.g.*, Niven v. Siqueira, 487 N.E.2d 937 (Ill. 1985) (holding peer review reports absolutely privileged). *But see*, Cameron v. New Hanover Memorial, 293 S.E. 2d 901 (N.C. 1982) (granting privilege to medical review committee, the court declared that the privilege which was qualified and only attached to communications made in good faith); Dorsten v. Lapeer County Gen. Hosp., 88 F.R.D. 583 (E.D. Mich. 1980) (denying absolute privilege which had been granted by state statute to a physician's employment discrimination suit brought under

Some courts recognize that incident reports serve the same purpose in improving health care as peer review committee reports and that they deserve the same protection from discovery in order to encourage the candor necessary to promote better patient care.[115] An Arkansas court extended the medical review privilege to include hospital reports from a "quality-care committee" which had disciplined a nurse after the death of an infant.[116] In *Gallagher v. Detroit-Macomb Hospital Association*,[117] a Michigan court held that because "hospitals are required to review their professional practices and procedures to improve the quality of patient care and reduce morbidity and mortality,"[118] under Michigan law, an incident report which was forwarded to the hospital safety committee after a patient fell from bed was privileged from discovery.[119] Judge Cor-

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federal law), some courts narrowly construe their interpretations of statutory peer review committee privilege to include only those statements made to a specially designated committee whose singular function is physician evaluation. *See* Gallagher v. Detroit-Macomb Hosp. Ass'n., 431 N.W.2d 90 (Mich. 1988) (citing Marchand v. Henry Ford Hosp., 398 Mich. 163, 167 (1976) in which the court applied Michigan's Public Health Code to determine that "[t]his privilege may only be invoked for records, data and knowledge collected for or by an individual or committee assigned a review function"). *See also* John C. Lincoln Hosp. & Health Ctr. v. Superior Court, 768 P. 2d 188 (Ariz. 1989) (granting privilege to peer review and trauma committee reports but denying privilege to a "Quality Assurance Program Incident Report").

Others only grant privilege to confidential communications directly related to patient care. *See, e.g.*, Dunkin v. Silver Cross Hosp., 573 N.E.2d 848 (Ill. 1991); Clark v. Norris, 734 P.2d 182 (Mont. 1986) (privilege of a document is limited by the purpose in requiring the report). Incident reports describing accidents involving visitors and staff are not afforded the same measure of confidentiality by these courts as those describing incidents affecting patients, and their subject matter is not considered to be privileged information. The courts believed the purpose of the reports was to improve *patient* safety. Although the corrective measures which would improve safety for staff and visitors might also improve care for patients, for example, patients often use the same stairways and walk on the same wet floors as staff and visitors. Thus, the court felt it necessary to limit the scope of what might be considered privileged. Notwithstanding some courts have held "slip and fall" incident reports to be privileged communications in a general corporate context (*see, e.g.*, Sears Roebuck & Co. v. Scott, 481 So.2d 968 (Fla. 1986); Payless Drug Stores, Inc. v. Sabido, 127 Cal. Rptr. 4 (1976)), this note confines the quality assurance privilege argument to incidents which are found to directly impact patient care.

115. *See* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970); Flannery v. Lin, 531 N.E.2d 403 (Ill. Ct. App. 1988) (holding that a code blue report prepared during the resuscitation of an infant was privileged); infection control committee report case. *See also* Laws v. Georgetown Univ. Hosp., 656 F. Supp. 824 (D.D.C. 1987) (extending privilege to include the internal memorandum of a physician which discussed problems with the delivery of a child).

116. National Bank of Commerce v. HCA Health Servs. of Midwest, Inc., 800 S.W.2d 694, 701 (Ark. 1990).

117. 431 N.W.2d 90 (Mich. Ct. App. 1988).

118. *Id.* at 93.

119. *Id.*

coran of the D.C. Circuit Court made one of the eloquent public policy arguments for extending peer review privilege to the reports of other committees.[120] Arguing for confidentiality of hospital staff meetings which were held to evaluate the causes of a patient's death, he said, "[c]onfidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients."[121] He further described confidentiality in this context as "an overwhelming public interest."[122] Health care workers would be more likely to openly provide important information to these committees via incident reports if confidentiality were consistently guaranteed by a quality assurance privilege.

2. State Legislation Establishing Hospital Incident Report Privilege

Several states have passed statutes specifically addressing privilege for hospital reports other than those used for medical staff peer review.[123] Some of these statutes specifically exclude incident reports, placing them in the same category as documentation contained within the medical record.[124] Even where these medical peer review committee privilege statutes provide specific language, such as the privilege "shall not be construed to include incident reports," judges have sometimes differed as to whether an evaluative report, prepared to prevent further accidents and to alert the attorney as to a possible claim against the hospital, fits under the statutory section denying privilege to routine documentation, or whether it more closely fits in the same category as peer review reports.[125]

120. Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970), *aff'd* 51 F.R.D. 187 (D.D.C. 1970).

121. *Id.* at 250.

122. *Id.*

123. *See, e.g.*, ARK. CODE ANN. § 16-46-105 (Michie 1990); OHIO REV. CODE ANN. § 2305.251 (Baldwin 1991); ILL. REV. STAT. ch. 110, par. 8—2101 (1985). These state statutes mention other types of hospital reports besides the medical peer review committee reports.

124. *See, e.g.*, OHIO REV. CODE ANN. § 2305.251 (Baldwin 1991); ARK. CODE ANN. § 16-46-105 (Michie 1990).

125. *See* State, ex rel Children's Medical Ctr. v. Brown, 1990 Ohio App. LEXIS 3008, April 12, 1990, *rev'd* 59 Ohio St. 3d 194 (1991) (the lower court interpreted the Ohio statute to include privilege for hospital incident reports but this position was reversed by the supreme court of Ohio); Flannery v. Lin, 531 N.E.2d 403 (Ill Ct. App. 1988) (granting privilege to a "code blue" incident report under the Illinois peer review report privilege statute); John C. Lincoln Hospital & Health Center v. Superior Ct. of Maricopa County, 768 P.2d 188 (Ariz. Ct. App. 1989) (refusing to equate an incident report with a peer review report for privilege purposes).

Some states expand medical committee peer review privilege to include documents prepared with the intention of improving the quality of health care.[126] Other state statutes mandate risk management programs as a condition for licensure of the hospital and do not specifically deny hospital incident reports privilege, so courts have been left to determine whether to broadly apply the state's medical peer review report privilege or exclude privilege for hospital incident reports.[127] Confusion and differing judicial interpretation even exists where standards for statutory interpretation have been established.[128] The statutes do not alleviate uncertainty for health care workers as to whether or not their communications in incident reports will remain confidential because the statutes have not put forth a clear privilege model. State legislatures need to adopt a uniform statutory hospital incident report privilege to provide hospital employees certainty that they may reveal their opinions to enhance health care without the threat of liability.

3. Subsequent Remedial Measures

The strongest argument for denying opposing access to hospital incident reports under a quality assurance privilege is the policy underlying the subsequent repair rule (also known as the subsequent remedial measure doctrine) of the rules of evidence: promoting safety measures.[129] The pertinent part of Federal Rule 407 states: "When, after an event, measures are taken which, if taken previously, would have made the event less likely to occur, evidence of the subsequent measures is not admissible to prove negligence or culpable conduct in connection with the event."[130] The common

126. *See* Illinois Medical Studies Act, ILL. REV. STAT. ch. 110, para. 8—2101 (1992); MASS. ANN. LAWS ch. 233, § 79 (Law. Co-op 1991).

127. *See* John C. Lincoln Health & Hosp. Ctr. v. Superior Court, 768 P.2d 188 (Ariz. Ct. App. 1989) (denying that peer review privilege protects quality assurance committee report); Ekstrom v. Temple, 553 N.E.2d 424 (Ill. Ct. App. 1990) (denying that peer review committee privilege protects infection committee report).

128. *See, e.g.*, Flannery v. Lin, 531 N.E.2d 403 (Ill. App. Ct. 1988) (interpreting the Illinois Medical Studies Act to extend privilege to a variety of hospital incident reports used in improving the quality of care); Niven v. Siqueira, 487 N.E.2d 937 (Ill. 1985); Sakosko v. Memorial Hosp., 552 N.E.2d 273 (Ill. App. Ct. 1988). *But see* Ekstrom v. Temple, 553 N.E.2d 424 (Ill. App. Ct. 1990) (interpreting the same Illinois statute to deny privilege to any incident reports other than narrowly defined peer review committee reports); Willing v. St. Joseph Hospital, 531 N.E.2d 824 (Ill. App. Ct. 1988).

129. FED. R. EVID. 407 advisory committee's note.

130. FED. R. EVID. 407. The second sentence contains the limitations on the exclusion: "This rule does not require the exclusion of evidence of subsequent measures when offered for another purpose, such as proving ownership, control, or feasibility of precautionary measures, if controverted, or impeachment."

law rule (codified in FED. R. EVID. 407) precludes admission of any evidence which shows that the defendant sought to correct a situation which led to the accident at issue to prove the defendant's negligence.[131] As a California court put it: "the quality of in-hospital medical practice will be elevated by armoring staff inquires with a measure of confidentiality."[132] The rule alone would not deny admissibility to incident reports because the reports themselves are not evidence of the subsequent remedial measures; they are used to identify problem areas which need correction.[133] This remedial, quality improvement purpose is thwarted, however, when the reports are admissible to demonstrate hospital negligence.

As the advisory committee note to Rule 407 suggests, "ground[s] for exclusion rest[] on a social policy of encouraging people to take, or at least not discouraging them from taking, steps in furtherance of added safety."[134] The public's interest in improving the quality and efficiency of health care is compelling and the full disclosure of staff member's evaluations of the nature and cause of "incidents" is critical to (1) assuring high quality health care through safe and efficient practices and procedures, and (2) decreasing risk to patients and losses to the hospital.[135] Although a party's admission is generally considered to be trustworthy,[136] when courts compel production of incident reports, their trustworthiness will inevitably diminish[137] because the health care provider preparing the report may not fully disclose all the circumstances which might in-

131. *See* Werner v. Upjohn, 628 F.2d 848 (4th Cir. 1980) ("Rule 407 is designed to protect the important policy of encouraging defendants to repair and improve their products and premises without the fear that such actions will be used later against them in a lawsuit").

132. Santa Rosa Memorial Hosp. v. Superior Court of Sonoma County, 220 Cal. Rptr. 236, 242 (1985) (citing Matchett v. Superior Court, 40 Cal. App. 3d 623, 628-29 (1974)).

133. *See* Rees v. Doctor's Hosp., Slip. Op. Case No. CA-5226, (Ohio 1980) (holding that the hospital's contention that incident reports should be privileged because of a public policy to improve health care was not sufficient to afford them that privilege).

134. *See supra* note 55 for text of Rule 407.

135. *See, e.g.*, Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970) (holding that the subject matter of hospital meetings are entitled to qualified privilege based on public policy); Duran, *supra* note 22, at 61.

136. *See, e.g.*, Gaddy v. State Bd. of Registration for the Healing Arts, 397 S.W.2d 347, 354 (Mo. 1965) ("A party's admission against interest of a material fact relevant to an issue in the case . . . is competent against him as substantive evidence of the fact admitted. And, for a statement by a party to be competent as an admission against interest, it is not necessary that it be a direct admission of the ultimate fact in issue, but it may be competent and of probative value if it bears on the issue incidentally or circumstantially").

137. *See* Note, *The Privilege of Self-Critical Analysis*, 96 HARV. L. REV. 1083 (1983) (noting that although the incident reports may continue to be factually accurate, less of the incriminating evaluative information will be included in them for fear of liability).

criminate him or his superiors.[138] For health care providers to keep the public interest in improving health care foremost in their minds when preparing incident reports, they must be able to rely on a consistent privilege standard so that they can be certain that what they report will not be used against them in court. They feel confident that, just as conduct which creates a safer situation is not admissible to prove negligence, neither should the tool used to point out the unsafe situation, the incident report, be admissible for that purpose.[139] Also, hospitals will be less likely to implement subsequent remedial measures if incidents go unreported, and they have no awareness of the problem until a lawsuit is brought against them.

An Ohio study demonstrates the problems created by reluctance on the part of staff members to prepare incident reports.[140] The hospitals surveyed revealed that they had no prior notification of approximately half of the incidents which resulted in legal claims against the hospital, that there were no incident reports prepared for thirty percent of those claims involving incidents in patient rooms, and no incident reports filed for seventy percent of emergency room incidents which resulted in suits against the hospital.[141] These hospitals' ability to limit risks to patients and themselves was severely limited by staff fear that they would be indicted for negligence by the use of incident reports.[142] If consistent quality assurance privilege attached to hospital incident reports, those problems that resulted in suits against the hospital, as well as those that did not but simply went unreported, could be called to the attention of quality assurance managers and attorneys and corrected as quickly as possible.

IV. MODEL RULE FOR HOSPITAL INCIDENT REPORT PRIVILEGE:

Society's compelling policy reasons for excluding hospital incident reports from discovery[143] and the courts' division of opinion

138. *See also* Duran, *supra* note 22, at 60, and Allan & Barker, *supra* note 27, at 561. Both articles note that fear of punitive actions discourages incident reporting.

139. *See* Marcia L. Finkelstein, *Comity and Tragedy: The Case of Rule 407*, 38 VAND. L. REV. 585, 610 (1985) (discussing "the social policy of encouraging people to take safety precautions").

140. *See* Duran, *supra* note 22, at 60.

141. *Id.*

142. *Id.*

143. *See* Doe v. St. Joseph's Hospital of Ft. Wayne, 113 F.R.D. 677, 678 (N.D. Ind. 1987) (discussing the policy reasons for peer review committee privilege, which are also

on the issue[144] together demand the establishment of a uniform rule of exclusion for states to adopt as a complement to existing medical peer review committee privilege statues. Courts have inconsistently applied state statutes addressing the issue of privilege for hospital incident reports because the laws have not delineated specific guidelines for discoverability and admissibility.[145] This model rule clarifies the existing ambiguous privilege standards as they apply to hospital incident reports. The rule establishes clear standards for incident report privilege to alleviate the uncertainty which discourages full disclosure of information by health care workers as much as the certainty of discoverability does. When health care workers know with certainty that what they reveal in incident reports will be used only to achieve two important objectives, to improve health care and to assist the hospital attorney in preparing a defense, and that it will not be revealed to plaintiffs' attorneys, they will more readily offer helpful information and opinions. If only one privilege is allowed, the hospital will certainly choose to protect itself from liability through the attorney-client privilege so the quality improvement objective will be lost. Just as a criminal's communications to his psychiatrist, his attorney, and his wife are all privileged because each communication carries a valid privilege in and of itself, so the hospital employee's communications to both the attorney and the quality assurance committee should remain confidential. Neither valid privilege should be defeated by the fact that more than one exists. This model rule provides that certainty for both the attorney-client privilege and the quality assurance privilege so that both the hospital's self-interest and the societal interest in better health care are preserved.

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analogous to those for incident report privilege, the court declared that "policing the quality and professionalism of Health Care Providers is an extremely high priority").

144. *See, e.g.*, cases granting hospital incident report privilege: Enke v. Anderson, 733 S.W.2d 462 (Mo. 1987); Sierra Vista Hosp. v. Shaffer, 56 Cal. Rptr. 387 (1967); Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970). Cases denying hospital incident report privilege: Clark v. Norris, 734 P.2d 182 (Mont. 1987); State ex rel Children's Medical Center v. Brown, 571 N.E.2d 724 (Ohio 1991); Bernardi v. Community Hosp. Ass'n., 443 P.2d 708 (Colo. 1968).

145. *See* State ex rel Children's Medical Ctr. v. Brown, 59 Ohio St. 3d 194 (1991) (interpreting OHIO REV. CODE § 2305.251 (Banks Baldwin 1991), the statute granting medical peer review privilege as inapplicable to hospital incident reports, though the lower court and dissent reached the opposite report). *See also supra* note 128 for Illinois cases reaching different results as to whether the peer review privilege statute applies to other types of hospital review reports.

MODEL RULE: HOSPITAL INCIDENT REPORT PRIVILEGE

To qualify for privilege from pretrial discovery and admissibility into evidence at trial the hospital incident report must:

(1) be prepared by witnesses within eight hours after the incident;
(2) not contain *factual* information unavailable to opposing counsel from alternate sources;
(3) be made by a hospital employee acting in good faith after an unusual or untoward event which could result in a legal claim against the hospital;
(4) be evaluative (critical) in nature, including, but not limited to, the witness' opinions and impressions regarding causation of the incident;
(5) provide recommendations for remedial measures;
(6) be delivered to the liability insurer, quality committee or individual, and risk management committee or individual within seventy-two hours after the incident;
(7) be clearly designated as "CONFIDENTIAL INCIDENT REPORT: FOR INTERNAL MANAGEMENT AND QUALITY ASSURANCE PURPOSES ONLY" (or an equivalent designation);
(8) contain the responses, remedial and disciplinary recommendations of the quality assurance or risk management personnel, and a timetable for implementation within ninety days after the incident.

The privilege may not be waived. Failure to adhere to any of the aforementioned requirements may subject the hospital to loss of the incident report privilege.

A. Preparation By Witnesses Within Eight Hours After the Incident

The more timely the declarations of witnesses, the more likely that their memories and perceptions will be accurate.[146] The Missouri courts recognized the importance of recording events in hospital incident reports while still "fresh in the mind of the person [who] witnesses or discovers the incident," both to rectify problem situations and to handle legitimate claims against the hospital "fairly and expeditiously."[147] Recommendations for QA and RM

146. *See* Lawrence M. Tribe, *Triangulating Hearsay*, 87 HARV. L. REV. 957, 958-59 (1974) (timely preparation would reduce the unreliability factor of "erroneous memory"); Jack B. Weinstein, et al, CASES AND MATERIALS ON EVIDENCE 247 (8th ed. 1988) (citing Brown, LEGAL PSYCHOLOGY 88-89 (1926) "[a]s time passes, memory falls off, sharply at first, then more slowly").

147. Enke v. Anderson, 733 S.W.2d 462, 464 (Mo. 1987).

must be based on reliable data if it is to produce meaningful remedial results. Plaintiffs must also have access to timely *factual* information, and some courts have denied privilege to incident reports because plaintiffs did not have access to the "timely declarations of the witnesses" without the use of the incident report at issue.[148] Hospital policy should require that the medical record documentation be completed within eight hours as well.[149] An Ohio court denied privilege to a hospital incident report when a patient was found "apparently dead" on the sidewalk outside the hospital. Plaintiffs, the decedent's family, sought a directed verdict for negligence and damages for the patient's pain and suffering prior to his death. Because the medical record was apparently an incomplete account of the circumstances leading to the patient's death, the court assumed without seeing it that the incident report prepared at the time of the incident would provide more information.[150] The incident report more likely would have been privileged if the medical record had been prepared thoroughly and in an equally timely and complete manner.[151]

Hospitals should establish internal guidelines to assure compliance with the eight hour requirement, such as noting the time and date of the receipt of the reports by the quality committee. Enforcement mechanisms and personnel are already present in most hospitals since quality control programs are statutorily mandated in many states[152] and are a prerequisite for national accreditation by the JCAHCO.[153] QA and RM committees can monitor compliance through random periodic chart audits and by comparing times, dates, and facts in the medical record with the entries in the inci-

148. *See* Rees v. Doctors Hospital, No. CA-5226 (Ohio Ct. App. 1980); White v. New York City Health & Hospitals Corp., No. 88 Civ 7536, 1990 LEXIS 3008.

149. *See* § B *infra* requiring that factual information be available to plaintiffs in the medical record.

150. Rees v. Doctors Hosp., No. CA-5226 (Ohio Ct. App. 1980). *See also* White v. New York City Health & Hospitals Corp., 1990 U.S. Dist. LEXIS 3008 (S.D.N.Y. March 19, 1990) (plaintiffs successfully argued for discovery of a hospital incident report rather than waiting to depose the witnesses because by the time of the deposition "memory has faded").

151. JCAHO and Medicare have established time limits for reporting to ensure accuracy of records. Though timing of preparation does not impact directly on the admissibility of hospital incident reports, the more accurate the reports are the more useful they will be for their intended purpose: discovering and correcting inefficient or dangerous situations in the hospital. *See* ROBERT D. MILLER, PROBLEMS IN HOSPITAL LAW 287-89 (5th ed. 1986).

152. *See generally*, Creech, *supra* note 105 for a discussion of state-mandated programs.

153. *See* Joint Commission on Accreditation of Hospitals, The Performance Evaluation Procedure (PEP) Primer and Other Materials (2d ed. 1975).

dent reports.[154]

B. Factual Information in Incident Reports Must Be Available To Opposing Counsel From Alternate Sources

Requiring hospitals to provide all the factual information in the medical record as well as in the incident report prevents the "veil of secrecy"[155] from being lowered by hospital defendants and their attorneys. Plaintiff's burden of proof is often particularly difficult to meet in the framework of a medical malpractice/hospital corporate liability suit.[156] Since hospital environments are foreign and highly technical to most plaintiffs, the latter usually must rely on the version of the facts provided by the hospital personnel who control access to those facts. This is especially true when an injured plaintiff was sedated or anesthetized at the time of the injury. The advantage to the defendant who documents the facts completely and accurately in both the medical record *and* in the incident reports is that generally the work product doctrine protects the opinion portion of the documents if the factual information they contain is obtainable from independent sources.[157]

The ideal incident report contains more than just the factual record of the incident. It contains the mental impressions of the witnesses, their opinions regarding causation, and their recommendations for corrective action. Defendant health care providers argue by analogy to the medical peer review privilege that to improve the quality of health care, hospitals must foster uninhibited professional criticism via confidential incident reports. To justify the argument, reports must contain more than just the facts contained in the medical record.[158] One case pointing out the importance of this

154. *See* GUIDO, *supra* note 16, and FIESTA, *supra* note 15, at 202-03 for a discussion of QA & RM auditing procedures.

155. Hickman v. Taylor, 329 U.S. 495, 506 (1947) (plaintiffs feared they would be disadvantaged by their lack of access to opposing counsel's investigative material).

156. *See* Clark v. Norris, 734 P.2d 182 (Mont. 1986) (denying a res ipsa loquitur instruction, the court nonetheless acknowledged plaintiff's difficulty in proving her allegation of negligence during an operative procedure).

157. *See* Moldovan, *supra* note 50, at 824 (stating, "[a]s a general rule, discovery of work product material will not be permitted if the information sought may be obtained by independent investigation such as interviewing or taking depositions of individuals from whom information is sought").

158. *See, e.g.*, Porter v. Snyder, 115 F.R.D. 77, 78 (Kan. 1987) (holding that incident reports are not privileged because they "are merely statements of fact"); John C. Lincoln Hosp. and Health Ctr. v. Superior Court, 768 P.2d 188, 191 (Ariz. 1989) (holding that peer review privilege did not protect incident reports from discovery because the incident report at issue was merely a contemporaneous account of facts contained in the medical record).

standard involved a hospital trauma committee which prepared an incident report after a patient injured in an automobile accident was brought to the hospital.[159] After suffering a cardiac arrest, the patient was resuscitated but sustained permanent brain damage.[160] Her family filed a subsequent negligence action against the hospital.[161] Although defendants argued that the incident report prepared by the trauma committee was protected by statutory peer review privilege, the Arizona court could find no reason to deny plaintiffs access to the report as it "constitute[d] only raw factual information which may trigger . . . discussion, exchanges and opinions" (the type of communications which would have been privileged under the Arizona statute).[162]

The rationale for hospital incident report privilege is not to deny the facts to plaintiffs, but to shield potentially inculpatory information which could prevent future incidents from occurring. Valid, constructive criticism which analyzes in detail the negative impact of a particular set of circumstances or actions by health care workers which resulted in an incident may be useful in correcting the problem. Such useful critique is discouraged if it may later be used as ammunition by opposing counsel.[163] A plaintiff's attorney may offer this self-critical analysis to exaggerate the fault contribution of the particular health care personnel involved. The hospital and health care workers may look worse in an incident report than in actuality, because speculation as to causation does not necessarily indicate actual causation, but may provide clues to ascertain the truth about causation.[164] Using incident reports in an accusatory fashion for either harsh internal disciplinary action[165] or in a legal

159. John C. Lincoln Hosp. & Health Ctr. v. Superior Court, 768 P.2d 188, 189 (Ariz. Ct. App. 1989).

160. *Id.*

161. *Id.*

162. *Id.* (referring to ARIZ. REV. STAT. ANN. § 36-445).

163. *See* Brendice v. Doctors Hospital, Inc., 50 F.R.D. 249, 250 (D.D.C. 1970), *motion reargued and denied*, 51 F.R.D. 187 (D.D.C. 1970), *aff'd mem.* 479 F.2d 920 (D.C. Cir. 1973) (declaring that "[c]onstructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit").

164. *See* Appendix A for sample incident report. The portions of the report calling for speculation are clearly separate. A person trained to review the reports and evaluate the information contained within could investigate the speculative information for accuracy. Hostile plaintiffs' attorneys would use the information to inculpate the parties.

165. *See* Allan & Barker, *supra* note 27, at 561, and Duran, *supra* note 22, at 60 (discussing the deterrent effect of harsh internal on disclosure of information in incident reports). Though not at issue in this note, these articles address constructive, non-threatening forms of discipline and anonymous means of reporting incidents to encourage their remedial objective.

action, diminishes their main objectives of quality enhancement and loss prevention.[166]

In addition to the hospital's internal enforcement mechanisms[167] for comparing the factual account in the medical record with that of the incident report, the plaintiff's attorney may request that the judge perform an *in camera* inspection to compare the incident report and corresponding portions of the medical record during the pretrial discovery period.[168] Even in jurisdictions where there is a statutory bar to discovery and admissibility of "[a]ll information, interviews, reports, statements, memoranda or other data . . . used in the course of internal quality control . . . or for improving patient care," courts have held that this language does not bar *in camera* inspection.[169] Courts have interpreted such statutory language in some instances to include a privilege for hospital incident reports, and, in other cases, to be limited to reports prepared by committees whose purpose is quality assurance or risk management in response to the incident reports.[170] The initial determination of whether the reports meet the standard for privilege should therefore be left to the judge's discretion.[171] Hospital attorneys and QA committees are less likely to manipulate the information in the incident reports for self-interest if the *in camera* inspection motion is available to the plaintiffs.[172] Because this model rule encourages consistent preparation of incident reports, plaintiffs will not have to

166. *But see* B. Abbott Goldberg, *supra* note 51 (arguing idealistically that, to the contrary, health care workers are unaffected by the presence or absence of privilege; they are always striving to provide better quality care).

167. Discussed *supra* in § A.

168. *See generally,* Porter v. Michigan Osteopathic Hosp. Ass'n, Inc., 428 N.W. 2d 719, 722 (Mich. App. 1988) (holding that *in camera* inspection is proper in determining whether or not evidence claiming privilege in fact meet the privilege requirements).

169. *See* Marsh v. Lake Forest Hosp., 519 N.E. 2d 504, 507 (Ill. 1988); *see also* Santa Rosa Memorial Hosp. v. Superior Court, 220 Cal Rptr. 236, 239 (1985) (holding court can appropriately hold an in camera hearing to determine disclosure of records or reports of a medical staff committee).

170. *See* Illinois cases interpreting the Illinois Medical Records Act, ILL. REV. STAT. 1985, ch. 110, par. 8, § 2101-2105, to mean that hospital incident reports are privileged. Niven v. Siqueira, 487 N.E.2d 937 (Ill. 1985), and Sakosko v. Memorial Hosp., 522 N.E.2d 273 (Ill. App. 1988) (holding that hospital incident reports are privileged); Marsh v. Lake Forest Hosp., 519 N.E.2d 504 (Ill. 1988), and Richter v. Diamond, 483 N.E. 2d 1256 (Ill. 1985) (denying privilege under the statute).

171. *See* Villano v. State of New York, 534 N.Y.S. 2d 664 (1985) (holding that even though the incident report was statutorily privileged, the judge could at his discretion after an in camera inspection release parts of the report to plaintiff's because the factual information contained within was not available to them from another source); *see also* Porter v. Michigan Osteopathic Hosp. Ass'n., 428 N.W.2d 719 (Mich. 1988)).

172. *See* Waldman, *supra* note 58, at 493.

guess whether or not the report exists; they can assume it does and move early in trial preparation for the *in camera* inspection. If the medical record appears to contain an incomplete account of factual information, plaintiff's attorney can make specific requests to guide the judge's examination of the report in the motion for inspection.

C. Hospital Employees Must Act In Good Faith In The Preparations Of Incident Reports After An Incident Which Could Result In A Legal Claim Against The Hospital

The hospital incident report privilege must meet the general requirements for a qualified privilege: "(1) communication made in good faith; (2) the subject and scope of the communication is made in good faith; (3) the communication is made to a person or persons having a corresponding interest, right, or duty."[173] Although made in the course of business, the subject matter of the incident report should not be considered "routine" business for the purposes of the business records exception to the hearsay rule (FED. R. EVID. 803(6))[174] because the report documents unusual events.[175] Because the goal is loss *prevention,* the likelihood of a resulting legal claim should be broadly interpreted to include even remote possibility of a liability action, contrary to some recent court decisions constricting the "prepared in anticipation of litigation" work product immunity requirement.[176] Hospitals would then be more likely to utilize incident reports to correct relatively minor problems, in addition to se-

173. Note, 61 N. C. L. REV. 1126, 1134 (1983) (citing Cameron v. New Hanover Memorial Hosp., 293 S.E.2d 901, 915 (N.C. App. 1982)).

174. *Id.* at 1126; *see also* Sligar v. Tucker, 267 So. 2d 54, 55 (Fla. Dist. Ct. App.), *cert. denied,* 271 So. 2d 146 (1972) (finding hospital incident reports prepared for the hospital's liability insurer were "not a part of the hospital business records").

175. At least one court has argued against considering hospital incident reports to be business records because incident reports are prepared when the hospital fears a legal claim may be brought, they lack reliability as business records when offered by the hospital. Picker X-Ray Corp. v. Frerker, 405 F. 2d 916, 921 (8th Cir. 1969). The implication is that health care workers may be motivated by self-interest in protecting their jobs and shielding themselves from personal liability and therefore may not be totally honest in documentation of incidents. *Id.* at 921.

176. *See* Sims v. Knollwood Park Hosp., 511 So. 2d 157 (citing Diversified Indus. v. Meredith, 572 F.2d 596, 604 (8th Cir. 1977) ("[t]he work product rule does not come into play merely because there is a remote prospect of future litigation"); Kay Lab. v. District Court, 653 P.2d, 721, 722 (Colo. 1982) (citing Hawkins v. District Court, 638 P.2d 1372, 1379 (Colo. 1982) (holding that there must be a " 'substantial probability of imminent litigation over the claim, or a lawsuit had already been filed.' Without such a showing, there is a presumption that the documents were prepared in the ordinary course of . . . business").

rious ones which may lead to death or disaster.[177]

Courts which have applied a narrow proximity to litigation definition[178] have done so to prevent parties from abusing attorney-client or work product privilege. Such parties have made sweeping declarations that records are privileged because they were forwarded to the attorney and that, in "today's litigious society," whenever there is a negative outcome, the possibility of a law suit is very real.[179] The incident report privilege, as established in this model rule, remains a narrow privilege, applied to a specific document, with a specific purpose: the information of health care (with a derivative effect, loss prevention). Hospitals may not circumvent the policy of open medical records[180] by broadly claiming the privilege for reports that do not meet the standards contained within this rule.[181] The burden of proof will still be on the hospital to demonstrate to the court that the incident report meets the privilege standard and that the medical record does not conceal any facts from opposing counsel.[182]

Courts hesitate to grant privilege to hospital incident reports because the concept of privilege runs counter to the underlying policy of the discovery rules—to ensure that all parties have access to all the relevant facts.[183] The federal discovery rules indicate a trend

177. *See* Creech, *supra* note 105, at 215 (discussing the purposes of incident reports).

178. *See supra* note 176 for the proximity test cited in Diversified Indus. v. Meredith.

179. Clark v. Norris, 734 P.2d at 187.

180. *See generally* GUIDO, *supra* note 16; FIESTA, *supra* note 15, at 173-93; COURNOYER, *supra* note 17.

181. *See* John C. Lincoln Hosp. & Health Ctr. v. Superior Court, 768 P.2d at 191 ("the mere fact that a committee has obtained evidence does not render that evidence privileged if it was not previously privileged") (quoting Humana Hosp. v. Superior Court, 742 P.2d 1382, 1388-89 (Ariz. App. 1987). *See also* Ekstrom v. Temple, 553 N.E. 2d 424 (Ill. App. Court 1990) (requiring that one who claims privilege in infection control records must show the facts that give rise to it); Clark v. Norris, 734 P.2d 182, 187 (Mont. 1987) (denying work product immunity to a hospital incident report the court declared "[a] privilege cannot be created in a subject matter merely by transmitting it to an attorney . . . [but] [i]f the employer directs the taking of a report for confidential transmittal to its attorney, the communication may be privileged") (citing Sierra Vista Hosp. v. Superior Court, 56 Cal. Rptr. 387, 392 (1967)).

182. *See* Ekstrom v. Temple, 553 N.E.2d 424, 430 (Ill. App. Ct. 1990) (citing Cox v. Yellow Cab Co., 337 N.E.2d 15, 17-18 (Ill. 1975), quoting Krupp v. Chicago Transit Authority 132 N.E.2d 532, 536 (Ill. 1956) " '[o]ne who claims to be exempt by reason of privilege from the general rule which compels all persons to disclose the truth has the burden of showing the facts which give rise to the privilege. 'His mere assertion that the matter is confidential and privileged will not suffice' "). The Ekstrom court recommends *in camera* inspection as the means to determine that the privilege standard is met.

183. *See, e.g.*, Villano v. State of New York, 534 N.Y.S. 2d 664 (N.Y. Ct. Cl. 1985) (refusing to grant privilege to psychiatric hospital incident report because of the patient's need for the information); Bernardi v. Community Hosp. Ass'n., 443 P.2d 708 (Colo. 1968)

toward a broad scope of discovery.[184] To decide whether or not privilege applies, courts must balance the self-incriminating value of incident report evidence with the plaintiff's right to secure the truth.[185] If the hospital makes the factual information readily available (so that the "substantial need" and "undue hardship" requirements of rule 26(b)(3)[186] are met) to opposing counsel through the medical record, it tips the scale in favor of privilege for hospital incident reports.

The health care provider must have prepared the incident report with candor and without self-interest or ill-will, however, in order to secure the privilege. An objective good faith standard is necessary to enforce this requirement of the model rule. The *Uniform Commercial Code* contains one example of a statutory definition of "good faith": "honesty in fact in the conduct or transaction concerned."[187] *Black's Law Dictionary* states that a good faith "encompasses, among other things, an honest belief, the absence of malice and the absence of design to defraud or to seek an unconscionable advantage."[188] Determining whether the incident report maker acted in good faith is a question for the judge to determine at his or her discretion based on the *in camera* inspection of the incident report. If there are glaring discrepancies in the medical record, if witnesses' accounts vary widely, if there are blanket accusations without foundation, or the appearance of deception, the judge has discretion to choose to deny privilege.[189]

(denying hospital incident report detailing the circumstances surrounding a surgical procedure which resulted in further injuries, because of the patient's need for the information).

184. *See* FED. R. CIV. P., Discovery Rules and Advisory Notes.

185. *See* Williams, *supra* note 50, at 435 (noting the argument that privilege "violate[s] the public's right to every man's evidence," quoting United States v. Bryan, 339 U.S. 323, 331 (1950)); Waldman, *supra* note 58, at 476 (analogizing attorney-client privilege with the privilege against self-incrimination).

186. *See supra* note 48 for full text of FED. R. CIV. P. 26(b)(3). The 1970 amendments to the rules eliminated the lower standard for exceptions to privilege which required that the party requesting production of a document only show "good cause" for the request, not substantial need nor an inability to obtain it without undue hardship from another source. *See* FED. R. CIV. P. 26 advisory committee notes (1970).

187. U.C.C. § 1-201(19) (1977).

188. BLACK'S LAW DICTIONARY 693 (5th ed. 1990).

189. *See supra* notes 168, 169 and accompanying text for cases regarding judges' discretion regarding admission of what would otherwise be privileged after in camera inspection reveals a reason to deny privilege. However, again the problem reliability arises if the report appears to contain dishonest information or malicious intent to implicate another as the cause of the incident. *See supra* note 47; Picker X-Ray Corp. v. Frerker, 405 F.2d 916, 924 (8th Cir. 1969) (incident reports designed to defend litigation contained statements by unnamed persons, could not be substantiated).

D. The Incident Report Must Be Evaluative (Critical) In Nature, Including, But Not Limited To, The Witness's Opinions And Impressions Regarding Causation The Incident

Under an attorney-client privilege analysis, courts either have applied a higher threshold of discoverability for or have disallowed opinion evidence.[190] If the witnesses include mental impressions about extenuating circumstances which may have contributed to the incident, they create a more useful document for quality control and risk management, but this self-critical analysis may also be self-incriminating.[191] For example, if a confused patient fell and broke her hip after climbing over the side rails of the bed, the medical record would document the details of the fall, the patient's mental status, any medications which the patient may have been taking which would contribute to the confusion, x-rays that were taken after the fall, and the radiologist's interpretation of the x-rays. The incident report would include all of these details and also the fact that two nurses called in sick for that shift so that it was impossible to provide constant monitoring for the patient, that the design of the bed was not adequate to restrain the patient because the side rails were too easily disengaged, or, that the nurse had previously reported to the patient's physician that medication X caused the patient to become very disoriented and the physician refused to discontinue the medication.

In the hands of the hospital attorney and risk manager, the additional information in the incident report would be used to develop a contingency nursing staff which could be called upon when the regular staff did not report to work. The attorney could advise the risk manager about the potential for negligence action for failure to provide adequate staffing, and the risk manager could work with nursing administrators to determine how many additional staff would be necessary to alleviate this problem. The incident report would prompt the hospital to purchase special restraints or alter the design of beds and side rails for confused patients. The hospital would undertake an investigation of the physician's rationale for continuing to prescribe medication X (perhaps the therapeutic benefit to the patient outweighs the negative effect—the confusion) or

190. *See, e.g.,* Clermont, *supra* note 48, at 758 (noting the various privilege requirements); Hyland & Forman, *supra* note 48, at 17 (discussing the different standards of admissibility for opinion information).

191. *See* Waldman, *supra* note 58, at 479 (balancing the problem of self-incrimination against the need for the incriminating information).

monitor the physician's competence if this is not the first report of a medication error by this particular doctor. Or, it could be used to report to the pharmaceutical company that a particular drug produced an untoward effect, which could prompt further research as to dosage, indications, and alternates for the drug.

In the hands of a plaintiff's attorney, the additional information contained in the incident report could be used to demonstrate that the nurses were negligent in their lack of vigilance to the patient and that the hospital was negligent in its failure to provide adequate staffing, appropriate equipment, or competent physicians.[192] It could be also used to prove willful negligence on the part of the physician in continuing to prescribe a medication after notification that it produced an untoward side effect.

To encourage health care workers to openly communicate more than just raw factual information in incident reports, the reports should include both open-ended questions and space for narrative explanations and comments.[193] An environment of trust and encouragement of honest communication should be fostered by hospital administration, and staff should be rewarded rather than punished for thorough documentation.[194]

E. The Incident Report Must Provide Recommendations For Remedial Measures

The ultimate goal of incident report privilege is to encourage corrective action (the FED. R. EVID. 407 rationale). To achieve this goal hospitals must create incentives for health care workers to do more than document the facts and speculate as to causation; they must require suggestions for change and improvement.[195] The employee who witnesses an accident, or is directly involved in causing it, is often in the best position to correct the situation. In other situations, an impartial expert, such as a risk manager, maintenance engineer, infection control nurse, or medical director may be in a better position to analyze the incident after it occurs and to propose remedial measures.

192. The information might also be used to instigate a products liability action against the pharmaceutical company and the bed manufacturer.

193. *See* Duran, *supra* note 22, at 60.

194. *Id.*

195. This model rule acknowledges that in some instances accidents are not preventable and therefore no corrective action may be necessary. In those cases, the incident report might contain a statement like "after careful analysis of the circumstances surrounding the incident no remedial measures are recommended at this time."

Cases which have granted privilege to hospital incident reports or memoranda generated by individual health care providers or staff committees by analogizing them to peer review committee privilege have done so when the purpose of the report has clearly been to improve the quality of hospital practices and procedures.[196] Hospitals gain a lot of valuable information by evaluating the safety of new brain surgery techniques,[197] the appropriateness of certain types of patient restraints,[198] whether nursing rounds are being performed frequently enough to monitor the patients sufficiently,[199] causes of a patient's death,[200] or the circumstances surrounding the birth of an infant with cerebral palsy.[201] If the particular problem is addressed openly by the parties involved (the brain surgeon, the nurses, or the obstetrician), then risk managers and quality assurance personnel, as well as the hospital attorney and insurer can make suggestions for correcting the problem.

Cases which have denied privilege to hospital incident reports have disregarded their useful purpose in undertaking subsequent repairs. *Porter v. Snyder*[202] acknowledged the policy reason behind the peer review committee privilege: " 'to protect the public's general health, safety, and welfare,' "[203] but believe that this objective was accomplished by the reports coming *out* of the review committee, rather than the reports going *to* the committee for evaluation.[204] The *Porter* court, however, did reserve final judgement on the incident report until it had performed an *in camera* inspection to determine whether it might be helpful in formulating subsequent remedial measures.[205] *Dunkin v. Silver Cross Medical Center*[206] denied privilege to incident reports of "slip-and-fall" accidents on the hospital stairs, though the hospital CEO argued that the purpose of the reports was to evaluate and correct problems "to improve the

196. *See, e.g.*, Niven v. Siqueira, 487 N.E.2d 937 (Ill. 1985); Laws v. Georgetown Univ. Hosp., 656 F. Supp. 824 (D.D.C. 1987); Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187 (D.D.C. 1970); Gallagher v. Detroit-Macomb Hosp. Ass'n., 431 N.W.2d 90 (Mich. Ct. App. 1988).

197. Niven, 487 N.E.2d at 939.

198. Gallagher, 431 N.W.2d at 92.

199. *Id.*

200. Bredice, 51 F.R.D. at 187.

201. Laws, 656 F. Supp. at 825.

202. 115 F.R.D. 77 (D. Kan. 1987).

203. *Id.* at 78 (quoting KAN. STAT. ANN. § 65-4925(a) (Supp. 1986)).

204. *Id.*

205. *Id.*

206. 573 N.E.2d 848 (Ill. App. Ct. 1991).

quality of care and service."[207] The *Dunkin* court decided that the privilege only extended to reports relating to medical care of patients,[208] and Ms. Dunkin was a visitor at the hospital. The court seemed to ignore the fact that patients and hospital staff members also used the stairs, and that the reports would be useful for everyone if the dangerous situation were corrected.

To enforce the policy of the subsequent remedial measures rule, to be certain that hospital incident reports are used to improve the quality, safety, and efficiency of hospital care, QA and RM personnel must periodically monitor the reports, assessing and implementing any viable recommendations made in them for improving the quality of hospital care, and adding any additional observations and recommendations they have. In addition to the hospital's internal monitoring of the reports, JCAHCO and liability insurers must periodically review incident reports and follow up to determine whether or not measures are successful in reducing patient and hospital losses.

F. Incident Reports Must Be Delivered Within Seventy-two Hours After The Incident To The Liability Insurer, Quality Assurance Committee Or Individual, And Risk Management Committee or Individual.

If hospitals wish to preserve the quality assurance privilege as well as the attorney-client privilege, they must ensure that the persons responsible for making health care improvement recommendations also receive the incident report. Unless the appropriate parties receive the incident report soon after the incident occurs, its remedial purpose cannot be achieved in a timely manner.[209] Under an attorney-client privilege analysis only *communications* are protected and information is not considered a communication until it is received.[210] *Bernardi v. Community Hospital Association*,[211] denied privilege to a hospital incident report prepared by a nurse after a

207. *Id.* at 849.

208. *Id.*

209. *See* 18 HOSPLW 5 (Feb. 1985) (discussing St. Louis Little Rock Hosp. Inc. v. Gaertner, 682 S.W.2d 146 (Mo. App. 1984).

210. Hyland & Forman, *supra* note 48 at 20-21 (discussing what constitutes confidential "communication"): *see also In re* Death of Francis *supra* note 57 (stating "[t]here could be no privileged communication without the receipt of the communication by the attorney"). In a standard communication model there is a sender, a message, and a receiver. *See* DANIEL K. STEWART, THE PSYCHOLOGY OF COMMUNICATION 24 (1968).

211. 443 P.2d 708 (Colo. 1968).

seven year-old girl sustained permanent injuries from an antibiotic injection because the report was prepared only at the hospital administration's request and was not delivered to the hospital attorney.[212] The court did not recognize a separate quality assurance privilege. The *Bernardi* court recognized that the report lacked usefulness in preparation for litigation (defendant hospital's argument), just as it would lack usefulness in training the nurse in proper injection technique if it were not forwarded to RM or QA personnel. Other cases have also denied privilege for hospital incident reports under a work-product doctrine because the reports were not sent directly to the hospital attorney.[213] These decisions fail to recognize that incident reports have another purpose besides alerting the attorney to possible lawsuits—to improve the quality of health care through the implementation of corrective action. If the incident report in *St. Louis Little Rock Hospital v. Gaertner*,[214] for example, were sent to hospital QA and RM personnel, the attorney, and the insurer with the certainty that its contents would remain confidential, future alcoholic patients might be prevented from drinking toilet bowl cleaner to commit suicide. This could occur because housekeeping staff would feel free to discuss how the patient might have had access to the dangerous substances without fear that such information might be used to prove that the housekeeper was negligent.[215] If the appropriate personnel receive the incident report within three days, correction of housekeeping procedures could occur, such as placing locks on janitor carts and closets, before other patients injure themselves.

Incident reports are useful in the aggregate because they spot unsafe trends in hospital care.[216] Such unsafe trends could include an inordinate amount of medication errors in a particular nursing unit that could indicate an under staffing problem if medications are consistently given late; a need for staff education as to methods of

212. *Id.* at 715.

213. *See, e.g.*, St. Louis Little Rock Hosp. v. Gaertner, 682 S.W. 2d 146 (Mo. Ct. App. 1984) (holding that the client must communicate with the attorney in order for the incident report to be privileged); *In re* Francis, *supra* note 57 ("how can there be communication to counsel when the person who initiates the communication does not know it is going to counsel?").

214. 682 S.W. 2d 146 (Mo. 1984).

215. *Id. Gaertner* did, however, recognize the relationship of *prompt* reporting to privilege when it denied privilege to reports which were collected and sent to the insurer on a monthly basis. *Id.* at 150.

216. *See* Allan & Barker, *supra* note 27 (discussing the uses of pharmacy incident reports); Duran, *supra* note 22, and Creech, *supra* note 105, at 215 (discussing general incident report purposes).

administration of drugs if, for instance, the nurses are crushing pills for patients who cannot swallow, but the crushing decreases the effectiveness of the medication; a high rate of infection could indicate the need for more isolation rooms and equipment such as masks, gowns, and gloves. If incidents are reported in a timely manner such trend information is more useful both to the hospital's internal risk management and quality improvement programs, and to external monitoring agencies which assess hospital outcomes for reimbursement and accrediting purpose.[217]

QA and RM personnel should distribute statistical reports which track incident trends at least quarterly in order to implement timely corrective measures. Timeliness monitoring, comparing the time and date of incidents in the medical record to the time and date of incident reports and their receipt by committees responsible for developing and implementing remedial action plans, should be conducted diligently by the QA and RM hospital personnel and periodically reviewed by JCAHO. JCAHO currently reports to hospitals in their accreditation reviews whether or not each hospital is in compliance with the risk management guidelines for incident reporting.[218] Some hospital and physician malpractice insurance carriers also monitor the frequency of incident reporting.[219] These practices should continue and include timeliness monitoring to preserve the timely quality improvement goal of incident reports.

G. Incident Reports Must Be Clearly Designated As "Confidential Incident Report: For Internal Risk Management and Quality Assurance Purposes Only (Not a Part of Medical Record)" Or An Equivalent Designation.

This provision addresses the dual arguments advanced by some courts to deny hospital incident report privilege.[220] Where incident reports have been used both for internal quality assurance and to alert the hospital attorney of a potential legal claim against the hospital, some courts have held that the dual purpose disqualifies the reports from privilege.[221] This position ignores the fact that the

217. *See* sources cited *supra* note 216.

218. *See* JOINT COMMISSION ON HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL (1992), *supra* note 180.

219. *See, e.g.*, St. Paul Fire and Marine Insurance data, P.I.E. data.

220. *See* Bernardi v. Community Hosp., 443 P.2d 708 (Colo. 1968); Clark v. Norris, 734 P.2d 182 (Mont. 1986); State ex rel Children's Medical Ctr. v. Brown, 571 N.E.2d 724 (Ohio 1991).

221. State ex rel Children's Medical Ctr. v. Brown, 571 N.E.2d 724 (Ohio 1991) (holding that a report prepared both to seek the attorney's advice and for quality assurance purposes

dual purposes are at least equally compelling, and the interest in subsequent improvement of hospital care may be even more compelling to the public than the interest in assisting the attorney to defend claims against the hospital. The Ohio appellate court judge in *State ex rel Children's Medical Center v. Brown*[222] recognized this public policy when he determined that the incident report at issue was "not part of the patient's medical record" and was "absolutely privileged as an attorney-client communication and as a report made available to a utilization committee,"[223] because honesty in the reports was essential to obtaining sound advice on the situation described in them.[224] *Sierra Vista Hospital v. Shaffer*[225] granted privilege to an incident report sent to the insurer which contained the heading "CONFIDENTIAL REPORT OF INCIDENT (NOT A PART OF MEDICAL RECORD),"[226]declaring that even though the report had more than one purpose, the dominant purpose of preparation for litigation controlled.[227] *Sakosko v. The Memorial Hospital*[228] granted a hospital incident report privilege even though it was "shared" by a variety of committees because all were responsible "for internal quality control, medical study and . . . improv[ing] patient care."[229] *Enke v. Anderson*[230] granted privilege to an incident report which had the words 'Incident Report Form . . . Not a part of medical records,' noting the "[s]everal benefits . . . derived from prompt reporting [of incidents]: Corrective action can be taken. The facts of the occurrence are fresh in the mind of the person who witnesses or discovers the incident. Many potential claims against the hospital can be eliminated or, at least, controlled."[231] This court understood that loss prevention and quality improvement were *both* important objectives of the incident report.

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was not privileged); Clark v. Norris, 734 P.2d 182 (Mont. 1986) (report prepared for both the liability insurer and internal administrative purposes was not held to be privileged); Bernardi v. Community Hosp. Ass'n, 443 P.2d 708, 715-16 (Colo. 1968) (denying privilege to incident report the "primary purpose" of which could not be determined).

222. No. 11638, 1990 Ohio App. LEXIS 3008 (Ohio Ct. App. Apr. 12, 1990) (per curiam), *rev'd* 571 N.E.2d 724 (Ohio 1991).

223. *Id.* at 3, 5.

224. *See* 24 HOSPLW 34 (Jan. 1991).

225. 56 Cal. Rptr. 387 (1967).

226. *Id.* at 392.

227. *Id.* at 392-93.

228. 522 N.E.2d 273 (Ill. App. Ct. 1988).

229. *Id.* at 274.

230. 733 S.W.2d 462 (Mo. Ct. App. 1987).

231. *Id.* at 464-65.

Quality assurance and risk management (liability loss prevention) activities are inexorably linked.[232] Although courts are presently split on the issue of privilege for dual purpose hospital incident reports, applying a special designation to the forms to indicate that they are not a part of the medical record alerts the health care providers who prepare them, the parties who later evaluate them for RM and QA purposes, and the judges who examine them *in camera* that they are "restricted" documents to be used to develop higher standards of care.[233] Preprinted forms, designed by the hospital attorney and/or the QA and RM committees,[234] with both narrative portions and blanks for responses to specific questions from the attorney, insurer and QA director, should be submitted to JCAHO for approval under the quality assurance guidelines.[235]

H. Incident Reports Must Contain The Responses, Remedial And Disciplinary Recommendations Of Risk Management or Quality Assurance Personnel, And A Timetable For Implementation, Of All Recipients Within Ninety Days After the Incident

The persons responsible for monitoring and recommending health care improvement measures must take action in a timely manner to correct problems in health care delivery—to achieve the very purpose of the incident report. These persons need not have the specific title of "Quality Assurance Director" or Risk Manager. They may include the hospital attorney, the liability insurer, a peer review committee, a quality assurance director or committee, a risk manager or risk management committee, a nursing administrator, or a maintenance and engineering director. Measures undertaken within a relatively short period of time will prevent further injuries or problems resulting from the same set of circumstances. Ninety days allows sufficient time for thoughtful examination of the problem and potential solutions by all parties involved.

Courts granted the privilege of self-evaluation to hospital inci-

232. *See* Puetz, *supra* note 27, at 247 (discussing quality assurance and risk management activities); JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, AMH ACCREDITATION MANUAL (1992) (guidelines for quality assurance and risk management activities); Monagle, *supra* note 22, at 28-29 (discussing risk management activities which improve quality of health care).

233. *See* Hyland & Forman, *supra* note 48, at 20-21 (discussing "[h]ow to keep communications privileged").

234. *See* Appendix A for sample incident report form.

235. JCAHO ACCREDITATION MANUAL FOR HOSPITALS (1992), *supra* note 180.

dent reports in *Bredice*[236] and *Laws*[237] to promote the kind of exchange of information which could lead to the improvement of hospital care. This goal was reaffirmed in *Penland v. Georgetown University Hospital*[238] when the court noted the "significant public interest served by promoting frank internal evaluation of hospital procedures and practices, hopefully resulting in enhanced patient care."[239] A nurse had filled out an incident report and sent it to a director of nursing at the hospital after a patient suffered pain and scarring from an intravenous line.[240] The report was intended to elicit the director's responses and recommendations regarding amelioration of the incident.[241] Statutes establishing peer review privilege also acknowledges this evaluative purpose.[242]

Just as timely reporting of incidents is essential to taking effective corrective action, so is a timely response to the reports.[243] If recommendations for and implementation of subsequent remedial measures occur well after the prompting incident, the risk of additional incidents and claims increases. Circumstances may have changed which compound an existing problem as well. This is especially true if there is a maintenance problem that the staff fails to report such as a leaking roof which results in a slip and fall the first time and later a serious head injury when a huge chunk of soggy ceiling tile comes loose, knocking a patient or visitor unconscious; or a short in an electrical system which results in minor shocks at first and later electrocutes a patient. Hospitals should establish internal monitoring mechanisms through existing RM and QA personnel to ensure that recommendations and follow-up corrective actions based on incident reports are timely as the reports themselves.

I. Waiver

The privilege may not be waived by the hospital or any other party to the incident report. Generally, hospital employees operate

236. 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973).

237. 656 F. Supp. 824 (D.D.C. 1987).

238. No. CIV.A.87-1247, 1987 WL 25668 (D.D.C. Nov. 12, 1987).

239. *Id.* at 1.

240. *Id.*

241. *Id.*

242. *See* KAN. STAT. ANN. § 65-4915(3) (Supp. 1991); ILL. REV. STAT. ch. 110, para. 8-2101 (1990); MASS. GEN. LAWS, ch. 112 § 5 (1986); N.Y. CIV. PRAC. L. & R. § 3101 (Consol. 1991).

243. *See* CARROLL, *supra* note 30, at 91 (discussing "[c]orrective action" and "follow-up" quality assurance measures).

as agents of their employer hospital for liability purposes.[244] In some instances, however, plaintiffs have filed separate suits against nurses and other health care workers as well as the hospital and doctors. If any of the parties to the report, either the preparer, the parties named in the report as wrongdoers, or the hospital were allowed to waive the privilege in order to avoid personal liability, their defensive use of the report would defeat the policies of both the attorney-client and the quality assurance privileges. Parties who prepare and sign the incident report should take personal responsibility for the contents of the reports so that they can feel certain that their opinions and impressions will be kept out of court because failure to adhere to any of the model rule requirements may subject the hospital to loss of the incident report privilege. If the hospital employer is allowed to waive the privilege without the preparer's permission, the preparer's reliance on the confidentiality of the report will be shaken.[245] Health care workers will be more thorough and careful to comply with the model rule requirements if noncompliance results in forfeiture of the privilege and their confidential communications will be divulged. Although the hospital is the client, and under a corporate attorney-client privilege model would normally be the party entitled to waive the privilege of its employees' communications, in this case the employees must be certain that the hospital may not waive in order to encourage the communications in the first place. This non-waiver policy protects the policies of both the attorney-client privilege and the quality assurance privilege the confidential reports promote.

V. CONCLUSION

Safer, more efficient, consistent, and economical medical care is compelling societal interest, as is abating unnecessary expense of the malpractice crisis.[246] Quality assurance and risk management programs already required by national hospital accreditation boards

244. *See* HEALTH CARE REGULATION CASEBOOK (1990) (discussing corporate and vicarious liability for hospitals).

245. *See* Marcus, *supra* note 64, at 1615 (noting that "[t]he erosion [of confidence] that results from waiver must sometimes make that assurance [of confidentiality] seem hollow").

246. The American Bar Association's (ABA) recommendations regarding medical professional liability evidence the fact that it is not only health care workers who are negatively impacted by the proliferation of medical malpractice suits. The ABA suggests more licensing and disciplinary boards and risk management programs which will improve the quality of care delivered to patients as well as lowering hospital exposure to liability. A.B.A. Special Committee on Medical Professional Liability Report to the House of Delegates. (undated, unnumbered).

and some state statutes are facilitating improvements in health care. Quality assurance committees, risk managers, liability insurers and hospital attorneys can only make effective recommendations for improvement and discipline if the participants and witnesses of untoward events in the hospital will give complete, accurate and timely reports of these incidents and the circumstances surrounding them. Health care workers have a significant disincentive to reveal details about causation and fault and to suggest corrective action when such information could be used to prove their personal negligence in a liability claim against the hospital.

The protection of a definitive privilege standard is necessary to encourage the flow of information between health care workers and those in a position to change procedures and policies for the better. Existing privileges limit the scope of discovery and admissibility of certain evidence in general, but uncertainty as to whether privilege may or may not be granted by a court because standards remain unclear has the same chilling effect on disclosure of information as if no privilege existed. A privilege standard which ensures plaintiffs full access to the factual account of the incident, while at the same time protecting the confidential communications of health care workers who act in good faith to inform attorneys, insurers, QA committees and risk managers about dangerous situations and employees, will promote the flow of information and thereby raise the quality of health care.

REPORT TO QUALITY RESOURCE MANAGEMENT OFFICE

G. MEDICATIONS

01. ___ Missing
02. ___ Drug/dose
03. ___ Dose
04. ___ Route
05. ___ Frequency
06. ___ Time
07. ___ Dosage form
08. ___ Preparation
09. ___ Infiltration
10. ___ Fluid rate
13. ___ Technique
14. ___ Labeling
15. ___ Dispensing
99. ___ Other _____

Ordered:
Drug & Dose: _____
Rte: 01. ___ Topical
02. ___ Oral
03. ___ IM/SQ
04. ___ Peripheral IV
05. ___ Central Line
06. ___ Hickman/Broviac
07. ___ Multi-lumen
08. ___ Feeding Tube
99. ___ Other _____

Given:
Drug & Dose: _____
Rte: 01. ___ Topical
02. ___ Oral
03. ___ IM/SQ
04. ___ Peripheral IV
05. ___ Central Line
06. ___ Hickman/Broviac
07. ___ Multi-lumen
08. ___ Feeding Tube
99. ___ Other _____

For IV Meds Indicate
___ IV Piggyback
___ IV Push
___ Continuous

Given VIA
___ Infusion Pump
___ PCA/Epidural Pump
___ Enteral Feeding Pump

Procedure/Policy/Practice

01. ___ Patient Identification
02. ___ Use of Equipment
03. ___ Transcription
04. ___ Documentation
05. ___ Technique
06. ___ Knowledge
07. ___ Allergy Identification
08. ___ Equipment functioning
99. ___ Other _____

H. SKIN INTEGRITY
Location:
01. ___ Sacrum
02. ___ Buttocks
03. ___ Heel
04. ___ Elbow
05. ___ Shoulder
99. ___ Other _____

Stage:
Size:
Hospital Acquired?
___ Yes
___ No
Etiology:

I. OTHER TYPE OF OCCURRENCE

01. ___ Signed out AMA
02. ___ AWOL
03. ___ Self-inflicted
04. ___ Struck by tool/ equipment
05. ___ Patient's property
06. ___ Equipment functioning
07. ___ Use of equip.
08. ___ Fire
09. ___ Theft
10. ___ Response Time
11. ___ Pt. preparation
12. ___ Technique
99. ___ Other

J. ANESTHESIOLOGY

01. ___ Respiratory
02. ___ Neurological
03. ___ Spinal HA
04. ___ Acute MI
05. ___ Cardiac arrest
06. ___ Dental, injury
07. ___ Ocular injury
99. ___ Other

K. RADIOLOGY
Contrast Reaction
01. ___ Mild
02. ___ Moderate
03. ___ Severe
04. ___ Turnaround time
99. ___ Other _____

Assession # _____

L. LABORATORY

01. ___ Collection Technique
02. ___ Turnaround Time
03. ___ Results Reporting
04. ___ Patient Satisfaction
99. ___ Other _____

M. SURGICAL PROCEDURE

01. ___ Sharp count
02. ___ Sponge count
03. ___ Equipment count
04. ___ Sterile Field
05. ___ Technique
06. ___ Equipment functioning
07. ___ Use of equipment
08. ___ Trauma ___ limb ___ organ ___ skin
09. ___ Specimen
10. ___ Delay
99. ___ Other _____

DESCRIPTION
Descriptive/narrative about the reason for the occurrence of the event:

_____

_____

_____

_____

Review of circumstances surrounding conditions of the area at time of event:

_____

_____

_____

_____

N. EFFECT

00. ___ No apparent injury
01. ___ Adverse reaction
02. ___ Burn
03. ___ Concussion
04. ___ Contusion or laceration
05. ___ Retained foreign object
06. ___ Fracture
07. ___ Dislocation
08. ___ Perforation
09. ___ Sprain or strain
10. ___ Agitation or confusion
11. ___ Therapeutic delay
12. ___ Break in skin integrity
13. ___ Corneal abrasion
14. ___ Skin reaction
99. ___ Other

Physician notified: _____

Time: _____

O. TREATMENT

00. ___ None
01. ___ X-Ray
02. ___ Chemical intervention
03. ___ Sutures
04. ___ Surgery
05. ___ Monitoring/observation
06. ___ Restraints
07. ___ Skin barrier
08. ___ Therapeutic bed
09. ___ Consult
10. ___ Lab Work
11. ___ Compress
12. ___ Dressing
99. ___ Other _____

Physician's signature

_____

Did event result in prolonged stay?

___ Yes ___ No

FOLLOW UP

Recommendations:

_____

_____

_____

_____

_____

Actions:

_____

_____

_____

_____

_____

Signature of Unit/Department Manager: _____

Witnesses: _____ _____

	Staffing:	**Census** ____
FOR	RNs ____	Acuity
OFFICE	LPNs ____	Workload
USE	NUAs ____	AHPWI
ONLY		AHPPD
	RQMO#	